Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10c,e,f,15per1NF.G925,3/9/2012,WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 16 2012 3:05 Рм Evelyn Florence Carr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) **Director** 130-32-5554 76 1 □ M 2 🗓 F Jan 18, 1936 England Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location
Timonium
Gockeysville notified at 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore 10e. Street 428d Five Farms Lane 10f. Zip Code **21093** ò 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien is marked other the college testing occupational data associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Albert John Waters Evelyn Victoria May Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 434 Bentley Rd; Parkton, MD 21120 Department of Health an Important: If item 27 is nany injury or Attach Amanda Carr - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause meach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the contribution of the funeral director. sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Day Pregnant at time of death ed by the a 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 🗌 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Dice မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident work?
1 \sum Yes 2 \sum No injury 5 Pending ours after death.

leral Director: Aft
filled in by the fur Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar ly one

nth, Day, Year)

FEB 2

29b.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Why Shawery 67 or N. Charles St. Balthuare

Registrar's Signatu

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

License number 8215000

ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O2 :25 PM Physician/ 2012 Medical 4a. Facility Name (if not institution, give st 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Medical Center Baltimore If Under If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Davs **Director** items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9201 Funeral 20735 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me ones. Elementary/Secondary (0-12) College (1-4 or 5+) Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cooper-9201 Eldon Dr. Clinton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Garrison Forest OwingsHills, MD 2/24/2012 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H-East 1101 E. Noi-th Ave. Signatur of Funeral Service Licenses Baltimore MD 21202 Pa 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Implementate Cause (Final Onset and Death Physician/ directe or condition retting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury pronar Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, 3 Probably 4 ☐ Unknown 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No this certificate ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manne of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 24 hours after death. Funeral Director: At Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number B100568 10 N. Greene Street. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Larry Month Κ. Crawford February Medical 2012 4:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Springwell Senior Living Baltimore City If Under 1 Year If Under 24 Hrs Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 498-34-8918 1 XM 2 - F 76 Yrs Usual Residence of Decede May 15, Iowa 28a-f shov 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director the Medical Examiner must be notified Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 2211 W. Rogers Ave. 21209 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married b Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary (Secondary (0-12) College (1-4 or 5+) Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Crawford Dorothy Tolander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Dorsch / Daughter 402 Woodbine Ave., Towson, Maryland 21204 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite ö injury 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Feb. 23,2012Glen Burnie, Maryland 21. Signature of Juneau Security Licenses 22. Name and Address of FacilityAMBROSE FUNERAL HOME, INC. a alle 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. ZEMZINZ Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral clirector, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Other (Specify) 1 🗌 Yes ၉ FULL 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Aatural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [

State Registrar

29b. Signature a

addr

ass of person who completed cause of death (Item 23a) (Type, Print) M) 6701 31. Date filed (Month, Day, Year)

d title of certifier

32. Registrar's Signature

N

(narces

29d. Date signed (Month, Day, Year)

February 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	arylanc		artment of F tificate of L		and Men		ene eg. No. 20	12	05	504
	Physicia	ın/	1. Decedent's Name (First, Middle, L	,					N	ate of Death	Day	Year Yol2	3. Time o	f Death
په در	Medic Examin	eal er	George 4a. Facility Name (if not institution, g	ive street and number)	_		4b. City, Town, o		of Death	orvary	4c. County	of Death	7, 7	
			University of Maryl 5. Social Security Number 6			st birthday)	Balti If Under 1 Year	M 0		ate of Birth	l N	/A	ace (State o	er Foreign
v.	Funeral Director		296–18–7557 Usual Residence of Decedent	1	88	Yrs.	Months Days	Hours	Min. (A	19/192	Year) 23	Countr	y)	or Foreign
	yland f shov ed at	ctor	10a. State 10b. County		10c. City,	Town or Loc						10	d. Inside C	ity Limits
	e Mar r 28a- notifi	Director	MD BALTIN	MORE		PAR	VILLE 10f. Zip Code			1	0g. Citizen of V	Mhat Count		5 2 LA NO
	th with th ms 23a o must be	Funeral	8810 WALTHER BLV		202	Lac	2123		: '-0 (0't- V		US	A		
9800	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🛛 No			, etc.)		e - America k, White, et	c.	
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Maryland 21215-0036	2 should be filed th and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Las ANDREW CHUVALA	t)					er's Name <i>(Fir</i> s VNA DAL		laiden Surname	e)		
Man	~ ~ ~ =		19a. Informant's Name/Relationship				g Address (Street							21224
	and Hea tern		KATHRYN E. CHUVA 20a. Method of Disposition	ALE TALE	20b. Pla	ace of Dispo	WALTHER sition (Name of		APT.	2202	20c. Location -			21234
Baltimore,	nit. Page 1 artment of ortant: If it injury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1		TROS"GRE CEMETERY		2/28/2	012	CARNEY	, MD		
Balt	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	ensee MOO217		22	Name and Addre	ss of Facili			ON FUNE			P.A.
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	the death.								Approxima Interval Be	tween
d	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneum	onia	,							Onset and	Death
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0	cate be executed physician and sthe burial-transit	edical Ex	resulting in death) Last	Due to (or as a	a conseque	ence of):								
8760	ificate	Med	IF FEMALE:											
. Box 68	or Attending Physician: The law requires that the death certificate be executed biretoral death. Jirector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth at 1 Pregnant at g Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	Ру			23d. Dat	te of deliver nth [,	Year
P.O.	is that the		Part II. Other significant conditions	_		_		ven in Part	1.	23e. Did tob	acco use contr	ribute to the	e cause of o	death?
rds,	requires been sig should b	ted	Chronic Obstr.	octive Lun	9 1	iscas	e		— <u> </u>	1 \square Ye	es 2 No			
Division of Vital Records,	The law reate has be page 2 sh	Completed by								24a. Was an autops perforn	y F	Were autops orior to com death?	pletion of	available cause of
E R	ician: The certificate rector, pag		25. Was case referred to medical	1		_	26. PI	ace of Dea	ath (Check only	1 Yes 2	2 No 1	1 🗌 Yes 2	2 □ No _	
Vit	ysician: is certific director,	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 🗆 DOA Oth	er:	ursing Home 5		nce 6 🗆 Othe	er (Specify)		
JO L	ing Phys I. After this funeral d		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injur work	?		Describe hov	w injury occurre	∍d		
sior	I or Attending Phy after death. Director: After this d in by the funeral of	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be	ry - At hon	ne, farm, stre		Yes 2 L		ocation (Str	eet and Numbe	er or Rural F	Route Num	ber,
Divi	ital or urs afte al Dire		4 - nomiciae determine	building, etc	. (Specify)					City or Town,				
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check 2 Medical Exa	hysician: To the best of a miner: On the basis of ex urse Practitioner: To the	kamination	and/or invest	tigation, in my opinio	on, death o	ccurred at the til	me, date and	d place, and due	e to the caus	se(s) and ma	anner stated.
	To t		29b. Signature and title of certifier	e mo			29c. Licens	e number 2344	Ĺ		9d. Date signed			,
			30. Name and address of person wh	o completed cause of de	eath (Item 2	23a) (Type, F	rint)		-		bruary	d4,	2016	
-			Dina Ismail	22 South	Gre	ene	Street,	Bult	imorei	MD	21201			
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2 7 2	012 32 Registra	r's Signatu	T. April	ake							
D.1.11	DHMH 17 Rev 06-2011													

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical wn, or Location of Death 4c. County of Death **Examiner** Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year, 78 219-28-6066 Director 1**X** M 2 □ F 1933 West Virginia Sept 10, Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location aţ Director must be notified 1 ☐ Yes 2X No Pasadena MD Anne Arundel 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral USA items 23a 21122 582 6th Street death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. 1951-0 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 1954 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 carpenter home improvement Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Granille Dawson Margarett Ellan Wall other traumatic je 1 and 2 should by t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Petesen - daughter 1310 Honey Lake St; Las Vegas, NV 89110 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place injury or Important: I any injury o 4 X Donation 5 Other (Specify) Signatur of Euneral Se 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of Beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ NON disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: ISe 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ó Year Month Day 1 Yes 2 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed page 2 certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum_\) Nursing Home 5 \(\sum_\) Residence 6 \(\sum_\) Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0032186

Registrar

State

DNORTH GREENE SHEET RALL imore, MS 24201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 05506 Certificate of Death 3. Time of Death 0434 Am Decedent's Name (First, Middle, Last) 2 Date of Death Philip 25, 2012 Deigert Physician/ February Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Genera Howard Columbia toward County 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign , Age (In yrs. last birthday) Social Security Number **Funeral** 219 18 1361 87 Director 1 XM 2 ☐ F Dec.21, 1924 Maryland Usual Residence of Dece show 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County Director Maryland Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a in any hipry or other traumatic event, the Medical Examiner must be once. Funeral 3943 Bayville Rd. 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces rces; 2 No WW Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give WW II Year or Dates 1943/46 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Telecommunication Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alice Mansfield Phillip John Deigert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Deigert Tanner (Daughter) 8001 Garden Gate Ct. Ellicott City, Maryland 21043 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/27/2012 Baltimore, Maryland Bayview Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 Signature of Funeral Service Licenses Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Atherosclerotic Coronary Vessel Disease Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific DØØ53312

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State Registrar 31. Date filed

Cause of death (Item 23a) (Type, Print)

Cedar Lane, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05507 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ William M. Downing <u>6:15a</u> ^M 19, 2012 Feb Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Future Care--Winchester/Sandtown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Director 218-09-3732 Jun 8, 1920 Usual Residence of Decedent show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Director r 28a-f st notified a 1 XYes 2 No MD **Baltimore Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or than "natural", or items 23a of the Medical Examiner must be Funeral 307 Gwynn Avenue 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 👿 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver **Federal Government** t. Page 1 and 2 should be filed with thent of Health and Mental Hygien trant: If item 27 is marked other 1 jury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Noah M. Downing Mary Cropper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Downing 307 Gwynn Avenue Baltimore, MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, permit. Page Department o Important: If any injury or Feb 25, 2012 4 Donation 5 Other (Specify) **Maryland National Park** Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Dysphagia months disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Vascular Dementia vears Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension vears and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 4 Pregnant 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulti*n*g i*n* the underlyi*n*g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Prostate Cancer, Deepvein Thrombosis Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia, Weight Loss 24a, Was an has page 2 performed? Yes 2 No this certificate 1 Yes 2 No Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and address of person who completed cause of death (Item 23a) (Type, Print MU 802 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorsey 45 A 2012 February nna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 934 Palladi Drive Halethorpe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 218-42-2730 66 1 M 2 Tr Yrs 07-05-1945 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🙀 No **Baltimore** Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21227 934 Palladi Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 😿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3XXWidowed 4 ☐ Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 10 <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ၉ Anna Frances Hooker Clinton H. Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. 934 Palladi Drive, Halethorpe, Maryland 21227 Lisa M. Munley - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X MBurial 2 Cremation 3 Removal from State Meadowridge Mem Park | 02-21-2012 | Elkridge, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd. Elkridge, MD 21075 Part 1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End-Stage COPD disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atter Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 2 🗌 No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractitioner: To the best of my movel by course at the firm, date and place and due to the cause (s) as different stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) nsrajapahreM D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209. Z835 5203 JMIN AV N.S. RajapaKse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 7 2012 Registrar

X

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES WESLEY ELGIN FEBRUARY 2012 5:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 213-32-5502 1 ፟M 2 □ F **Director** 2/18/1937 75 MARYLAND show ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1X Yes 2 No MD BALTIMORE CITY 10e. Street and Number 10g. Citizen of What Country? Funeral death with 1650 WOODBOURNE AVENUE 21239 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", 3 Widowed 4 X Divorced Completed Year or Dates Mental Hygiene.
narked other than "natur 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) PLUMBING-HEATING Elementary/Secondary (0-12) College (1-4 or 5+ 12TH GRADE BUYER marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 CHARLES H. ELGIN FERNITA SNYDER . Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONY C. ELGIN/SON 149 BEACHFIELD DR. REBOBOTH BEACH, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 2/27/2012 PARKVILLE, MD 4 Donation 5 Other (Specify) Signature of Fungal Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MOO217 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ou Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. il any, leaving to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown detached signed by ti Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No မ 1 Yes ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 Pyes 2 No 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or d title of cer 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar Name and address of

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person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

18215000

1St. *405, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24 2012 10:12AMM Ella Whirley Etzler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6218 New London Rd New Market Frederick 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 217-30-6658 1 □ M 2 💢 F 77 29, 1935 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shorury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Frederick New Market Md 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 USA 6218 New London Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hayden Whirley Mamie Atkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen W. Etzler, Sr. / husband 6218 New London Rd. New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/27/12 Resthaven Mem Gardens Frederick, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signatur of Funeral Service Licept athanine (11802 Liberty Rd. Libertytown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Completed by Physician/Medical P.O. Box 68760 as the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death 1 ☐ Yes ∠ ₩ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospita Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? s after death.

I Director: After t Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a

State Registrar DHMH 17 Rev 06-2011

completed cause

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 7:58 A Albaugh Helen Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year)
Dec 24 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours 1 M 2 K F Months Days Min Director 87 1924 Maryland 212-24-5530 Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🏻 No Westminster Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21157 U.S.A. 3816 Ridge Rd. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) imported crafts/ life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) church service center pricer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Maude Nusbaum John David Albaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Taneytown, MD 21787 459 4th St. Jay D. Fritz/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State Pipe Creek Cemetery 2/28/2012 nr. Linwood, MD 4 Donation 5 Other (Specify) 21. Signil of Fureral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home Union_Bridge, MD 21791 6 Broadway Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Jrinar ection Vac Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Due to for as a consequence on: Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? After this certificate has funeral director, page 2: performed 1 🗌 Yes 2 🗎 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter a stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cen 3

State Registrar Rida

32. Registrar's Signature

e Road Westminster

21157

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHMOOD

31. Date filed (Month, Day, Year)

FEB 2 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 3:20 February Medical Clarence Foxworth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 3975 Warner Ave #A4 Landover Hills unk 8. Date of Birth U1 Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) unk **Funeral** unk Months 224-68-3185 Director 1 XM 2 □ F Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Landover Hills MD Prince Georges 10f. Zip Code 20783 10g. Citizen of What Country? 10e. Street and Number 3975 Warner Ave #A4 Funeral 12. Was Decedent Ever in U.S. Armed Forces? **unk**1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Examiner Black, White, etc. or ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: ian "natural", Medical Exar 3 Widowed 4 Divorced Completed within 72 hours 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the unk Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) of Health and Mental fitem 27 is marked ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Gallatin St; Hyattsville, MD 20781 19a. Informant's Name/Relationship (Type, Print) Prince Georges Police Dept. other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 A Other (Specify) in state Department of Important: If it any injury or o cemetery, crematory or other place) Ronald S. Kade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) ENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 ass IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NON INSULIN DEPENDENT DIMETERS 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed PERCHOLESTER TOLEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy OBACCO performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 X Yes 2 □ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9311 Annapolis Lanham mo dress of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) Registrar's Sign State FEB 27 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:31 110ve Medical 4a. Facility Name (if not institution, give street and number) **Examiner** of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** -90-0562 **Director** 1 M 2 F 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho items 23a or 28a-f shorner must be notified at 10a. State Director M 1 Lyes 2 No d 15 more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Rd 2/225 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 21 No Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) howse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department o Important: If any injury or -2012 . Signature of Funeral Sy Name and Address of Tacility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Pericardia Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Due to for as a consequence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE use f yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2 \(\subseteq \text{No.} \) 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 12152367 18,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Balkmore MD ireene

DHMH 17 Rev 06-2011

State Registrar

Wertho

7

31. Date filed (Month, Day, Year)

FER 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day 2 2012 3:18 A M Harry Reese Gamber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours **Director** 85 213-20-9677 1 X M 2 □ F Sept 18, 1926 Maryland Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Owings Mills Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 5 Pleasant Ridge; Apt 210 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗓 No þ Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Wallcrafters Inc. self employed 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Nellie Aliza Woolery Amos Ivan Gamber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Pleasant Ridge; Apt 210; Owings Mills, MD 21117 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen Gamber - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Euneral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, suffering failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCRUATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and I for use as the burial-transil that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed It Id be det 23e. Did tobacco use contribute to the cause of death? ģ DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 26. Place of Death (Check only one) Was case referred to medica Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

of Vital Records, Hospital or Attending Division

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated address of person who completed cause of death (Item 23a) (Type, Print) 31. Date ORIGINAL

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lillie F. Gravely 2012 11:25 Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing & Rehab Center Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 3/25/1927 Washington, DC Director 578-34-1735 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia (1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane apt. #182 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. or i 1 Never Married 2 Married 1 ☐ Yes 2 ☐MNo If Yes, Give ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n 5+ College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David R. Franks Lela Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 3842 Carpenter Street SE Washington, DC 20020 John Gravely/Step-Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/24/2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 X N death? Hospital or Attending Physician: The 1 ☐ Yes 2 🛛 No Yes funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 🔀 No Other: မ 4XX Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nu se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/22/2012 person who completed cause of death (Item 23a) (Type, Print) Andrew Lazris 6334 Cedar Lane Columbia, MD 21044 32. Pogistra State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 8:45 P ^M February 2012 Helen Elizabeth Harriman Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dundalk Baltimore Future Care North Point If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. Months 11/24/1919 Maine 1 □ M 2**X** F 036-12-7243 92 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21221 U.S.A. 946 N. Marlyn Avenue Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 Yes : 2 XNo Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Currier Lena George L. Stockwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 946 N. Marlyn Avenue, Baltimore, Maryland 21221 Ruth Pago (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Holly Hill Mem. Gard: 02/24/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Fastern Avenue, Essex, Maryland 21221 21. Signature of Funeral 85. ..., e Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physiciani) herasc discase or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Vear Month Day Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No ☐ Yes 2, 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Harsing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 Pending 1 Tes 2 🗌 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Day, Year) 29b. Signature and title of certifier 69540 12. M.D 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville MD 21232 Words Rd 204 8813 walk State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0551 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death FEBRUARY Physician/ 20 P M James Stephen Horvath Medical BACTIMURE Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 10WSON Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Director 214 56 5268 1 XM 2 □ F 63 02/05/1949 Maryland Usual Residence of Dec 28a-f show at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🔀 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Southwick Court 21286 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. an "natural", or Medical Examin þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 in the and Mental Hygiene.

7 is marked other than "r Department of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Transportation Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Senuik Mary other traumatic Joseph David Horvath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau and 2 s 1000 Southwick Court Towson Maryland 21286 Donna M. Horvath (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holly Hill Mem Garden's 3/1/2012 Baltimore County, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA Fune III Service 1407 Old Eastern Avenue Essex MAryland 21221 art 1 Enter the disease, s oc or heart failure. Lis complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease - condition Onset and Death Physician/ Medical resulting in death) **Examiner** Esquentially liet our diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) sician a e burial-Physician/Medical Box 68760 the phy ding IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death the i P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 No 3 Probably 4 Unknown Records. Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? this certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ပ 1 X Inpatient 2 ER/Outpatient 3 DOA funeral n 24 hours after death.

Pe Funeral Director: After the pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 첩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day)

Registrar

DHMH 17 Rev 06-2011

State

. Name and address of person

Date filed (Month, Day, Year)

FEB 27

GOI USLER DRIVE TOWSON, MD

who completed cause of death (Item 23a) (Type, Print)

-NELSON

MAKOR

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2012 **Physician** 19 02:10 a Feb. SAMUEL ALEXANDER HALSEY, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Fort Washington Medical Center Fort Washington 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
July 21, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F NC 238-20-9759 1924 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Show 1 □ Yes 2x □ No ral", or items 23a or 28a-f sh Examiner must be notified Director Fort Washington Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 9615 Wedgewood Pl. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinada. 1 ☑ Yes 2 ☐ No If Yes, Give 1957 — Year or Dates: 197 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify: \$ Black 3 X Widowed 4 ☐ Divorced 1976 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Airforce 5+ Auditor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Walker ို Samuel A. Halsey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgewater, MD 21037 3493 Monarch Dr. Paul A. Halsey - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem 3-7-2012 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland 21. Signature of Funeral Service Licensee Victorine Suitland, MD 20746 4308 Suitland Rd . 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 □ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Impatient 1 ☐ Yes Certification: To After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after deat To the Funeral Director:

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of

m 23a) (Type, Print)

License number

761 UVINDA

29d. Date signed (Month, Day, Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Harriel Month Physician/ 0620 AM Fabruck 2012 Medical 4c. County of Death
Baltimers 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Randalls House Examiner Hospital ER-7 Northwest 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 423 30 169 1 M 2 Months Hours Min. Alabama Director Usual Residence of Decedent 28a-f show 10b. County within 72 hours after death with the Maryland at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗆 Yes 2 No Raltimore MD or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5412 USA traumatic event, the Medical Examiner must and Mental Hygiene. Is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home of Health and Mental Hygic of Health and Mental Hygic fitem 27 is marked other Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mosele elen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WindSDRMILL MD 21244 Harrie injury or other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State -12 Kandallstown 4 ☐ Donation 5 ☐ Other (Specify) Memorial 21. Signature // uneral Service Lice 16 70 Fredhilten Hass Bouto MD 21225 -Há 23a. Part 1. Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dyschythmia Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner 10 cardial STelevation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Cotonary and tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ≠ 9 ☐ Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital: 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d \$\$68783 February, 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar NWH

dewit

32. Registrar's Signature

Michael

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Month Physician/ $2:35P^{M}$ 201 Hardin Nellie S. rebruary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Accokeek Prince Georges Chatsworth Drive 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Country) GA **Funeral** -1914 OCt 14 Min 1 □ M 2 🕱 F Days **Director** 97 408-60-5222 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Accokeek Prince Georges 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States 20607 820 Chatsworth Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daisy Wallace Stanford Evan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 820 20 Chatsworth Drive Jan Roddy/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Waldorf, MD Gardens 2/24/12 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Hodges & Edwards F.H. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Silver Hill Rd., Suitland, MD. 20746 3910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 01 10 disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner?

1 \(\text{Yes} \quad 2 \text{No} \) funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

Reference of the filled in by the filled in by the filled in the filled in

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

3650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Branch Ave, Temple Hills, MD old 6104 Strakir M.D. Eunice

State Registrar

сотретер

within 2

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month [EBRUARY Day 17 Vaai Physician/ 17:11 2012 Haynes Edith Mae Medical 4a. Facility Name (if pot institution, give street and num Gity, Town, or Location of Death 4c. County of Death Examiner 10SPITAL /Lmore ear If Under 24 Hrs ays Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1-06-1929 Months 1 M 2 12 XF MD 215-24-4176 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo Lansdowne MD Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number United States 21227 900 Catawba Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2XXNo 1 Never Married 2XX Married ò If Yes, Give Year or Dates 1 ☐ Yes 2x xNo Specify: Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Vending Company Cafeteria Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Gertrude McCurdy Henry Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Catawba Court, Lansdowne, Maryland 21227 Wallace G. Haynes - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ™ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 02-21-2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Nome at uneral Service 21. Signature of Inc, 7250 Wash Blvd, Elkridge, MD 21075 MMP, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final inthoranial hemorrhhae disease or condition

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner unknown 214 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cones the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy has After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

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Falik

29b. Signature and title of certifij

Din 31. Date filed (Month D

address of person who completed cause of death (Item 23a) (Type, Print)

goo Catun

29c. License number

Avenue

D47353

Bultmore,

29d. Date signed (Month, Day, Year)

elosur

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? | | ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 23, 2012 7:47P.M Hornack Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Care Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 216-01-4663 **Director** 93 1 ★ M 2 🗆 F 1,1918 |Maryland Usual Residence of Decedent or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at by Funeral Director Baltimore City 1 X Yes 2 □ No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21222-1011 U.S.A 6738 Duluth Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Rail Road Engineer of Health and Mental Hygie of item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Annie Miklosovich John Hornack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Erie Avenue Baltimore, Maryland 21234 t of Health Tamie Ourand / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 N Burial 2 Cremation 3 Removal from State 9 permit. Page Department of Important: If any injury or 27,2012 | Baltimore, Maryland Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee M00933 1201 Dundalk Avenue Baltimore,Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner immon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dual o (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6★ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Acciden 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and little of certifier 2012 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSUN Charles N. MO 6701 31. Date filed State

P DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 612 FEDTUARY Physician/ Sr. aM Gordon Ennis Hart, Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not Institution, give street and number **Examiner** Greneral Baltimore tal maryland If Under 1 Year | If Under 24 Hrs 8. Date of Birth N & Onth, 2ay, 1e9 58 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. **Funeral** Hours Fromida 1 X M 2 D F Months 53 222-44-5318 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 XYes 2 No Baltimore City Md. 10g. Citizen of What Country? 10e. Street and Number Funeral 21224 1417 Broening Highway U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify. If Yes, Give Specify: 3 Widowed 4X Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) North Point Inn Culinary Chef To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Buck Anderson Emily Hart 19a. Informant's Name/Relationship (Type, PrintDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Broening Highway Baltimore, Md.21224 Naelyn E. Rodriguez Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Febrüary 1 Burial 2 Cremation 3 Removal from State 27,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland <u>Bayview Crematory</u> 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License M00933 Dundalk Avenue Baltimore, Md.21222 1201 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ in Furchion Acute yocandi. Medical resulting in death) Due to (or as a consequence of): Examiner Conunary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown heart 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy death? Kidney Chronic 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 LER/Outpatient 3 ☐ DOA 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check det the time, delle and place, and due to the Cartifying Nurse Practioners To the best of my knowledge, death under cause's and manner as stated unity units 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M D43386 2-22-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (toward 1714 Ectew Place +21 un 21201 Baltimore R. Danial

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 2 7 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ A^{M} James Arlie Jennings February 2012 1:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Hall Baltimore 36 Bangert Avenue 8. Date of Birth (Month, Day, Year) Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 238-34-9787 Director 1 **X** M 2 □ F North Carolina Yrs 06/22/1929 82 Usual Residence of Decedent with the Maryland 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Perry Hall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Bangert Avenue 21128 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Transmission Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sherman Jennings Lila McGlamery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Jennings 3829 Dance Mill Road, Phoenix, Maryland 21131 Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 DRemoval from State 4 Donation 5 Other (Specify) Bayview Crematory 02/24/2012 |Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. Signature of Fundamental Consecution 1407 Old Eastern Avenue, Essex, Maryland 21221 art. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Ph. i.i.n. 10NIA sulting in death) ease or condition Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate case. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p should be DEMENTIA 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy After this certificate Hospital or Attending Physician;
 24 hours after death.
 Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: Natural 5 \square Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature ap 29c. License number 29d. Date signed Month, Day, Year, 12 cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		Kegistrar	Certificate c	of Death		R	eg. No.	
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle, Last) Kenneth August Jarmer				2. Date of Dea Month February	th Day Year	3. Time of Death 2133 hrs
		Facility Name (if not institution, give street and number) Saint Agnes Hospital		4b. City, Town, or Baltimore	r Location of Death	ì	4c. County of Dea	ath
Funeral Director		215-78-6015	yrs. last birthday) 50 Yr	Months Day			th(MM/DD/YYYY) 9. E 5 1961	Birthplace (State or eign Country) Maryland
20y		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Loca	ation				10d. Inside City Limits
fand fshow	ē	MD Baltimore	Lansdo					1 Yes 2 No
h the Mary 3a or 28a- otified at	Director	10e. Street and Number 3231 Bero Road		10f. Zip Code 2122	7	1	0g. Citizen of What Co USA	untry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other thas "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 Married 1. Yes 2	lf '	Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puerto		White, etc.	erican Indian, Black, White
urs after tural",	آھ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete)			ation (Give kind of		Specify: 16b. Kind of Busines	
5-0036 led within 72 hou Tygiene. other thao "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		most of working life aintenan	e. DO NOT use ret	ired)	US Gover	nmant
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D 21215-00; should be filed within and Mental Hygiene. 7 is marked other that	8	Robert O. Jarmer Sr.			Edna N			
and 2 should and 2 should lealth and Me tem 27 is ma traumatic ex	٩	19a. Informant's Name/Relationship (Type, Print) Jo Ann Jarmer-wife	3231	Bero Ro	ad Lansdo		nber, City or Town, Sta cyland 2122	7
		20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo crematory or o	ther place)		Date	20c. Location - City o	
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	Glen Hav					ie Maryland of Lansdown
		Allhe Mous						Maryland 212
Physician ~ Medical		23a. Part I. Enter the disease, or complications that caused the distinct. List only one cause on each line.				or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Narcotic (Her Due to (or as a consequence)		xication				
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequential point of the conditions).	nce of):					1
- da	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	nce of):					
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760, icate be physicia	Medical	IF FEMALE: 23c. If yes, outcome of		r 78.			23d. Date of delive	ery
Division of Vital Records, P.O. Box 687 To the Bospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Physician/	23b. Was decedent pregnant in the past 12 months? 1	of do oth	etal death 3 Other (Specify)	Ectopic pregna	ancy	Month	Day Year
O. BC t the dez by the z		Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
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of Vital Records, ig Physician: The law require the tar this certificate has been sineral director, page 2 should be	Completed			· · · · · · · · · · · · · · · · · · ·		24a. Was autop perfo		autopsy findings available completion of cause of
tal Re(inn: The certificate		25. Was case referred to medical		26 Place	e of Death (Check	1 Yes		
Vita bysicia this cer al direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 ER/Outpatier		Other Nursin	ng Home 5	Residence 6 Oth	er:
n of ading P. th. :: After e funera	<u>.</u>	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of	· · · · · ·	ury at Work? Yes 2 🗶 No	28d. Describe unknow	how injury occurred	
Division To the Hospital or Attendit within 24 hours after death. To the Frocral Director: A completely filled in by the fi	Certification:	Accident Suicide 6 Could not be Fending Investigation 28e. Place of Injury -		o pm —		28f. Location (Street and Number or F	Rural Route Number, City
Div ospital or hours afte toeral Dir y filled in		4 Homicide determined (Specify) FO	ound:Resi			Baltimo	State) 3231 Bre ore County,	MD.
To the Howithin 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	-					
F 3 F 8	ŝ	29b. Signature and title of certifier		29c. Licen:			29d. Date signed (M	
d		30. Name and address of person who completed cause of death	(Item 23a)	0.C.	.M.E.		February 19, 20	JIZ
P		Laron Locke MD. Assistant Medical Examir		altimore Stree	et, Baltimore,	MD 21223		
Sta Regist	ate rar	31. Date filed (Manth Day Xear) 32. Registylr's Si	gniture					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / Dep	eartment of Health and I Prtificate of Death	Mental Hygien Reg. t	2012	05526
	Physicia		1 Decedent's Name (First, Middle, Last)	y Jackson		2. Date of Death	Day 20 Year	3. Time of Death 8. 20 A M
	Medic Examin		4a. Facility Name (if not institution, give st		4b. City, Town, or Location of Death		4c. County of Beath	
	Funeral Director		5. Social Security Number 6. Sex	Age (In yrs. last birthday) M 2 F Yrs.	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth Cour	place (State or Foreign
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	Feb. 11, 1	930 No. 1	L Carolina 10d. Inside Gity Limits
	the Mary or 28a-f e notifie	Director	Maryland N/r 10e. Street and Number	1	Baltimore 10f. Zip Code	10g. (Citizen of What Cou	
	ath with ems 23a r must b	Funeral	10e. Street and Number 4505 Pinlico 11. Marital Status		2/2/5 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	
9800	72 hours after death with the Manyland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, Specify: Bla	etc.
21215-0036	thin 73	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	edent's Usual Occupation kind of work done during most of work DO NOT use retired)	king]	endon F	og .
	uld be filed wi Mental Hygie narked other latic event, t	To Be	17. Father's Name (First, Middle, Last) Tunious Harrie	gton		ne (First, Middle, Maide Jon 25	en Surname)	
Maryland	12 shoulth and 27 is in traum		19a. Informant's Name/Relationship (Type Michels Mulligan-9	Print) 19b. Mail 19b. Mail 43	ling Address (Street and Number or Rui CheStruct Ave.		or Town, State, Zip	Code) 21204
Baltimore,	0 - 1		20a. Methor of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20h Place of Disp	position (Name of ematory or other place)		Location - City or To	own, State e Maryland
Balt	permit. Page Department of Important: If any injury of		21. Signature of Funeral Service Licensee	Parker 3	22. Name and Address of Facility Par 3512 Frederick A	Ker-Funer Ve Baltin	nore Ma	P.A. 2/229
h	Hysician/	, ,	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		pproximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	ulu Aceo	eul		
	red	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to jor as a conse juence of				
0	ate be executed physician and the burial-transit	edical Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
	ertificate ding physse as the	/Medi	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy			20d Date of deli	
). Box 687	requires that the death certific been signed by the attending is should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv	Day Year
ls, P.O.	uires that n signed t	by	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to t	he cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after dealth. Within 25 hours after dealth. To the Tunneral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed				24a. Was an autopsy performed?	prior to co	psy findings available ompletion of cause of
/ital	ysician: is certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	spital:	26. Place of Death (Chec	ck only one)	26.2930	Hotaine
on of \	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of injury (Month, Day, Year) 28b. Time of injury		ome 5 Residence 28d. Describe how inj		Hospice
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		l Route Number,
	ne Hospii in 24 hour ne Funera pletely fill	Medical	(Check 2 Medical Examine	an: To the best of my knowledge, death r: On the basis of examination and/or invergractitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	at the time, date and pla	ce, and due to the ca	use(s) and manner stated.
	Tot With Tot		29b. Signature and title of certifier	M.D.	29c. License number D0071287	29d. [Date signed (Month,	Day, Year)
	SV			npleted cause of death (Item 23a) (Type, 701 %. Chee les St		invere, N	102120	4
	Sta Registra		31. Date filed Wonth, Day, Year) FFR 2.7 20	32. Registrar's Signature	berel			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dok Jo Kim 2012 12:15 AMM February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia <u>Gilchrist</u> Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) Hours 218-02-4676 Director 1 🗶 M 2 □ F 74 Korea July 25, 1937 Usual Residence of Deceder 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar any injury. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Elkridge Maryland Howard 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Korea 21075 5935 Abrianna Way #D 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 👿 No Specify: Asian Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Yeon Cho Joon K. Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5935 Abrianna Way #D, Elkridge, Maryland 21075 Young Ja Kim - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Crest Lawn Mem. Park | 02/25/2012 Marriottsville, MD uneral Service L 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signatur f 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

MONTHS Immediate Cause (Final Physician/ IRRHOSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or). attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? EMPHYSEMA 24a. Was an cate has page 2 : performed; 24 hours after death.

Funeral Director; After this certificate Yes 2 No 1 Tyes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPILE ျှ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 X Natural 5 Pending work Accident 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

within 2

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MD

32. Begistrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

064395

6336 LEDAR LANE COLUMBIA, MD 21044

29d. Date signed (Month, Day, Year)

FEBRUARY 23. 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 05528 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 13, 2012 1050 hrs **Medical Examiner** Alfred 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Glen Burnie Anne Arundel 113 5th Avenue 5. Social Security Number If Under 1 Year I if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Director Country) Mary land 1 X M 2 F 11/14/1917 214-05-1783 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 Yes 2 No Glen Burnie Maryland Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 113 5th Avenue 21061 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: White 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Coast Guard 12 N/A Machinist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth William Kaiser ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health and it: If item 27 is other traumat 374 Lakeshore Drive Pasadena, Maryland 21122 Teresa M. Kepner (Personal Rep) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 02/25/2012 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee MOO-732 22. Name and Address of Facility Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland, failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Immediate Cause (Final disease aAtherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, per me, g925 3-1-12 sm UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed page 1 🗸 Yes certificate Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes ဥ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after ucca...

To the Funeral Director: A completely filled in by the fu 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. February 14, 2012 30. Jame and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. 32 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 220 February Medical 4a. Facility Name (if not institution, give street and numbe Examiner 4b. City, Town, or Location of Death 4c. County of Death General Baltimore naryland 5. Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month, Day, Year) Hours Country) MD Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore MO 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral Boulevard Washington USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ould be filed within 72 hours after the Mental Hygiene.

marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Memorial Elementary/Seconday (0-12) Callege (1-4 or 5+) Hospital harmacputical Tech Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Mar permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en ames E. Lee Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 19a. Informant's Name/Relationship (Type, Print) Moulton -lee (Wite 2536 Wash ungton Bowlevard, Apt. 2 Bailimore MD 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Baltimore, MD Greenmount-Crimatory 02/28/2012 4 Donation 5 Other (Specify) Vaugh C. Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randall Stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ noma disease or condition resulting in death) Medical **Examiner** Umona Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last ue to (or as a cons suitance of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) Yes 2 No 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State

Registrar DHMH 17 Rev 7/2009 only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

eted cause of death (Item 23a) Ffvpe. Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For	State of Ma	aryland	/ Depa	rtment of H	Health a	and Me	ental Hyg	giene			
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port	Examin	er	4a. Facility Name (if not institution, give	street and number)			4b. City, Town, o	r Location o	of Death		4c. Cd	ounty of Deat	h	
			7051 Carroll Ave				Takoma					ntgome	_	_
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under : Hours	24 Hrs. 8 Min.	 Date of Birth (Month, Day) 			hplace (State o untry)	or Foreign
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	and show	 e	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside C	ity Limits
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Σ	nd 2 sealth in 27 i		Lillian S. Love	Frederick-	DTR	7051	Carroll	Ave.	#					
ore	of Her of Her if iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Dameuel from Chate		ce of Dispos	ition (Name of atory or other plac	e)	Dat	te	20c. Loca	ition - City or	Town, State	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Europeal Service Licen	see A.W	rods	ク Ma 43	Name and Address 1rshall-N 308 Suit]	ss of Facility March Land F	Funer	ral Hom Suitlar	ne of	Maryla D 2074	and 6	
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89	certifi nding use a	n/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc						230	d. Date of deli	verv	
Box 687	eath e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 4 Pregnant at			Ectopic pregnand Other (specify)	у				Month		Year
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Division of Vital Records,	ding I h. After funer	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day	ry 28 /, Year)	Bb. Time of injury	28c, Injury work M 1 🗆	/ at ? Yes 2 □		d. Describe ho	w injury oc	curred		
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Phy	rsician: To the best of	my knowled	ge, death o	ccurred at the time	e, date and	place, and	due to the cau	use(s) and r	manner as sta	ated.	
	the H nin 24 the Ft nplete	Mec	only one) 3 L Certifying Nur	iner: On the basis of ex se Practitioner: To the	xamination ar e best of my l	na/or investi knowledge, i	gation, in my opinic death occurred at t	on, death occ he time, date	curred at the te and place	e time, date an , and due to th	d place, and e cause(s) a	a due to the c and manner as	ause(s) and ma stated.	nner stated.
_	Viit Con		29b, Signature and title of certifier	1	20		29c. License	number		2	9d. Date si	igned (Month,	Day, Year)	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** FEBRUARY ONG 23 2012 LIZABETH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dunda1k Baltimore 1935 Barry Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months **Funeral** 1 □ M 2 🖾 F Yrs Aug. 12, 1917 Maryland 94 Director 218-05-2439 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Funeral Director Dunda1k MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 21222 United States 1935 Barry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed by 3√□ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Health and Mental Hygiene. em 27 Is marked other than ther traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Cafeteria Food Service 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be William Sturm Mary Sweeney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland Creek Side Court permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. Karen A. Armacost (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 2/28/2012 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failer. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Physician DEMENTIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burlal-transit Due to (or as a consequence of): Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burla pe Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown HYPOTHYPOID 151 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2Z No or Attending Physician: After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 TYes 2 TNo death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

the 2

State Registrar 29b. Signature and title of certifier

5505 Hopkins Bayview Circle, Balt., MD 21224 JENNIFER HAYASHI

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

062032

29d. Date signed (Month, Day, Year)

FEBRUARY

			Please	Type or Pri					•		egible.	
			For	State of Ma	aryland				nd Mental Hy	giene	010	00000
			State Registrar			Cer	tificate of l	Death		Reg. No.	UIZ	05532
	Physicia Medio		Decedent's Name (First, Middle, Las Mat		J.	Lan	nasa		2. Date of De Month Februa	ary 23	2012	3. Time of Death 8:05 P M
	Examin	er	4a. Facility Name (if not institution, give				4b. City, Town, o		Death		unty of Death	
7005	Funeral		Stella Maris 5. Social Security Number 6. S		e (In yrs. la:	st birthday)	If Under 1 Year	nium If Under 24		rth	altimor	place (State or Foreign
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	rland f shov ed at	tot	10a. State 10b. County			, Town or Lo					1	10d. Inside City Limits
	Mary 28a- notifie	Jirec	Maryland Baltin	ore	T:	imoniu				40. 6'''	(1111 10	1 Yes 2 X No
	ith the	ral	10e. Street and Number 131 Hollow Brook	Poad			10f. Zip Code	.093		_	of What Coul	ntry?
	eath w	Funeral Director	11. Marital Status	12 Was Decedent F	ver in U.S.	. 13.			? (Specify Yes or No- Puerto Rican, etc.)	14.	Race - Americ	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ሺ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	^{No} iet N	Jam '	f Yes, specify Cuba 1 ☐ Yes 2 🔀 No		rueno Rican, etc.)		Black, White, cify: Whi	
9	hours natura lical E	lete	15. Decedent's E	ducation		16a. Deced	dent's Usual Occup	pation			of Business/In	
Maryland 21215-0036	nin 72 ne. han " " e Med	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5	i+)	life. D	kind of work done O NOT use retired)				<i>c</i>	
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and	be file ental I ked c ic eve	70	Alberico	Lamas	а			To: Wiother	Frances		entile	
any	hould and M s mar umat		19a. Informant's Name/Relationship (7			19b. Maili	ng Address (Street	and Number of	or Rural Route Numb	er, City or Tow	n, State, Zip	Code)
Σ,	ealth a m 27 i		Eileen Lamasa	Wife				ook Ro	ad Timon	1		
Baltimore,	ige 1 and not of H		20a. Method of Disposition 1 X Burial 2 Cremation 3 C		Diff	ratie vier	sition (Name of Valley pla	ce)	Date		ion - City or To	
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Ba	permit Depar Impor any in		11/11/11	ian			1050 Yor		Towson,			1204
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	Examiner		Toolston, and toolston,	Due to (or as	a consequ	ence of):						
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0	be exe sician burial		resulting in death) case	d								
68760	ficate g phys as the	Medi	VE SELVINS	d,								
Box 68	ath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	I death 3	Ectopic pregnan Other (specify)	су		23d	. Date of deliv	very Day Year
). B	hat the des ed by the a detached	hysi	9 🗌 Unknown	9 Unknown								
s, P.O.	gn be	þ	Part II. Other significant conditions	ontributing to death b	out not resu	ulting in the u	underlying cause g	iven in Part 1.		tobacco use o		he cause of death?
Records,	w require as been si 2 should I	Completed							24a. Was	s an 2	4b. Were auto	ppsy findings available ompletion of cause of
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ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		(Check only one)			
of Vital	Phys r this eral dii	년 ::	1 Yes 2 No 27. Manner of Death	28a. Date of inju	iry	28b. Time o	nt 3 🗆 DOA	4 L Nurs	sing Home 5 Res			W HOSPICE
on c	ath. r: After ne funer	icat	1 X Natural 5 Pending 2 Accident Investigation		y, Year)	injury	wor	k?]Yes 2□N	lo			
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the	Medical Certificate:	3 Suicide 6 Could not 4 Homicide determined				reet, factory, office			(Street and Nown, State)	ımber or Rura	l Route Number,
D	lospital 4 hours uneral ely filled	dical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	rsician: To the best of	my knowle	edge, death	occurred at the tim	ne, date and pl	lace, and due to the ourred at the time, date	cause(s) and r	nanner as sta	ted. ause(s) and manner stated
	To the Parithin 24 To the Factorial Somplet	Me		se Practitioner: To the				the time, date		the cause(s) a		stated.
			> MANINO	2 CANF			1219	1979	2_	2/2	4/201	12_
	•		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type,	Print)			- 1 -	1	
XI			JACKIE JONES, (ALLEY RD.	TIMO	NIUM, MD	21093		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7 2013	32. Registr	ars Signat	par	de l					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death WILLIAM FREDERICK LIST Physician/ FEB 9.25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Baltimore Examiner Augsburg Lutheran Home Lochern 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 213–32–5224 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Jan. 2 1931 1 🔀 M 2 🗆 F Maryland 81 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director **Baltimore** Baltimore or items 23a or 28a-f Maryland 1 ☐ Yes 2 🗓 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any niury or other traumatic event. 6825 Campfield Road, Completed by Funeral 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Korea White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Westinghouse Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernhardt List Mary M. Harman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte W. List (Wife) 6825 Campfield Rd., Apt. 11C2, Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 2/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polymak Funeral Home, P.A. Signature of Funeral Service tocensee Kevin E. Ecker MOO175 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHERUS CLEROTIC DISPASTOnset and Death EREBROVASCULAR Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) ending physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EIMERS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? Yes 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No 1 Yes Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0+ State Registrar DHMH 17 Rev 7/2009

29b. Signature and title of certifier

ASNEEM

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi

028595

Box 1525

OWINGS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ We to Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Seasons Hospice/NW Hospital Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. (Month, Day, Year) 220-76-3249 Director 1 🛛 M 2 🗆 F 65 1-3-1947 Maryland Usual Residence of Decede ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 X No Owings Mills Md. Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 21117 U.S.A. 11431 Cronhill Drive, Suite C Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene.
77 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Ň/A Disabled N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin Lewandowski Marie Kropp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Sliwinski/Aunt Linwood Avenue Baltimore, MD 21224 623 other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of H
Important: If ite
any injury or oth ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 2-22-2012 Baltimore, MD view 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral/Service License Dundalk Aveenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mei disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (cries a nonsequence of): burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the huria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year ed by the al Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No ours after death. eral Director; After this certifica filled in by the funeral director; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural work? 5 Pendina Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 24 hours a Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17.018 per Ana Bd G3/08/20012 III amend #1 Per PHYG925 3/22/2012 III Certificate of Death Reg. No. State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2012 3:46 Ам Robert K. Mowery Jr. SR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegheny Health Nursing Cumberland Allegany If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 23, 1926 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months Hours Min. Maryland Director 220-16-610 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 🗌 Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 618 1/2 Frederick St. 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? 1 A Yes 2 No 1945-Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 1947 Completed 3 - Widowed 4 - Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 machinst Be 17. Father's Name (First, Middle, Last)

Robert Kenneth Mowery Sr. 18. Mother's Name (First, Middle, Maiden Surname)

Minnie Flones

Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 1/2 Frederick St; Cumberland, MD 21502 Dorothy Mowery - wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Ronald Sy 22. Name and Address of Facility State Anatomy Board 21. Signature ector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Discare Pnysician Chronic Obstructure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam and-tran Due to (or as a consequence of): resulting in death) Last burial-t attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death ed by the a detached f Yes 2 No 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown been signature Completed 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director, After this certificate has to completed filled in by the funeral director, page 2.8 completed filled in by the funeral director, page 2.8 autopsy perform prior to completion of cause of death? 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify, Hospital: 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title ofcertifie 29c. License number 29d. Date signed (Month, Day, Year) 1)0033260 Feb 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allegany Ave Tol Cumber LAND MD KUMA ota 31. Date filed (Month, Day,) Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Physician/ 2012 5:40 <u>Doris Lucine McCall</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22, 1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Indiana Director 138-36-1077 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 USA 403 Russell Ave; Apt 410 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Year or Dates Completed 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ethel Vesa Johnston Samuel Parks McNaught 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15218 Forest Stone; San Antonio, TX 78232 19a. Informant's Name/Relationship (Type, Print) Linda Jordan - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Pinal Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Completed by Certificate: To Be

Division of Vital Records, P.O. Box 68760 al or Attending Physician: To s after death. Il Director: After this certifical

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) g Unknown	23d. Date of delivery Month Day Year							
Hypertens	contributing to death but not resulting in the underlying cause given in Part I. When the sum of t	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Anemia & Chronic Lisease, Pancicatel mass, Renul cys Ts, 24a. Was an autopsy prior to completion of cause death? 1 yes 2 No 1 yes 2 No									
5. Was case referred to medical	26. Place of Death (Check onl	y one)							
examiner? 1 Yes 2 No	Hospital: Other:	5 Residence 6 Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exa	hysician: To the best of my knowledge, death occured at the time, date and place, and duminer: On the basis of examination and/or investigation, in my opinion, death occurred at the urse Practioner: To the best of my knowledge, death occurred at the time, date and place, a	time, date and place, and due to the cause(s) and manner stated.							

04115

G41THERSBURB, MD

29d. Date signed (Month, Day, Year)

Fobruary 16, 2012

State Registrar

Medical

29b. Signature and title of certifier

14 Robert Desselle

30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) 20 / RUSSSLL AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05A M Je6 ONALD Medical Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4c. County of Death easons Hospice at Northwest Hospital Baltimore Randalls town 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Yea Hours Min. 156-12-3219
Usual Residence of Decede May 4, 1924 Director 1 X M 2 - F Pennsylvania 87 show 10a. State at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 💢 No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be i Funeral 21228 55 Wade Avenue USA items permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedon.
Armed Forces?
1 Yes 2 A No the Medical Examiner Black, White, etc. þ ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) unk unk self employed f Health and Mental Hygier item 27 is marked other other traumatic event, the moped & bike repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Mantz Elizabeth Ruth Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Boute Number, City or Town, State, Zip Code)
Adult Protective Services Shante Joanes - guardian 6401 York Rd 2nd flr: Balto. MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) in state Rona Id 22. Name and Address of FacilityState Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition rneymon Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician deed for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. ate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signa State 7 2012 FEB 2 Registrar

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	R	enistrar			Ceru	ilcale (Deali		12.	Reg Date of Death	g. No.		3. Time of Death
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Me al Examin		SALVADOR . 4a. Facility Name (if not in	ENRIQUE A	YALA M. t and number)	<u>ENDOZA</u>		4b. City, To	own, or Location		,, .		ounty of Death	
		SB Route 3 at R		t and manner,			Crofto	n			Anr	ne Arundel	
Funeral	٠,	5. Social Security Number		7. Ag	e (In yrs. las	t birthday)	If Unde	1 Year If Unde	er 24Hrs.	8. Date of Birth	(MM/DD)/YYYY) 9. Birth Foreign	place (State or
Funeral Director		NONE	1 _V M		3	4	Months	Days Hours	Min.	August	6,1	977 Cour	ntry)El Salvado
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Maryland 28a-f show d at once.	윉	10e. Street and Number					10f. Zip	Code		10	g. Citizer	n of What Count	ry?
he M.	Director	910 Easthar	m Ct					211	14		_	alvador	
with t	_ L	11. Marital Status	12. '	Was Decedent		. 13.	Was Decede	nt of Hispanic Ori Cuban, Mexicer	igin? (Spec	cify Yes or No-	14	 Race - Americ White, etc. 	an Indian, Black,
eath item	E	1 Never Married 2	2 Married 1	Armed Forces	X No						_ 1		
filer d	Ď.		Divorced If Yes	, Give Year				No specify				pecify: Lati	
ours a		15. Decedent's Education				16a. Deced	dent's Usual of most of wor	Occupation (Give	kind of wo Fuse retire	rk done d)	16b. Kin	d of Business/In	dustry
72 h	ie e	Elementary/Secondary	y (0-12)	ollege (1-4 or	5+)						Re	stauran	t
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Hygi de		17. Father's Name (First,		ictor	Manue 1	Ava	la			ilia Me			
121 d be f lental arke	B	19a. Informant's Name/R			ife)			(Street and Nu					Zip Code)
D 2 shoul ris m	٩	Ana JUlia P		,	,			AM CT #2			MD 2	111/	
md 2 salth 2 cm 2	ŀ	20a. Method of Disposition			20b. P	lace of Dis	position (Nar	ne of cemetery,		Date	20c. Lo	cation - City or	Town, State
of He Line	1		remation 3 R	emoval from S		ematory or Morre	other place)		03/0	02/12	Sant	a Cruz,	Cuzcatlan
Baltimore, MD 21215-0036 permit. Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5	Other Specify:					Address of Facili					
Sall ermit Separt mpor sjury		21. Signature of Funeral	Service Licensee	1		- 1							rvices, Inc
	\dashv	23a. Part I. Enter the dis	sease or complication	ons that cause	d the death.	Do not ent	er the mode	nnedy So of dying, such as	cardiac or	respiratory arr	est, shoc	k, or heart	Approximate interval
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	Ē	cause. Enter Underlying (Disease or injury that in	nitiated C.	to (or as a con	seguence of)·							
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n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and e funeral director, page 2 should be detached for use as the burial - transi	an/Medi	IF FEMALE:		Bc. If yes, outco	ome of pregr	nancv					23d.	Date of delivery	,
Box 68760, e death certificate be the attending physic of for use as the bur	N.	23b. Was decedent preg		Live birth	ome or prog.	2	Fetal death	3 Ector	pic pregnar	ncy	'	Month [Day Year
Sox 687 death certific e attending p		past 12 months?	4		at time of de	ath 5	Other (Spe	cify)	_				
Bo e deat the at	Physic	1 Yes 2 No 9					ha wadadwia	a cause given in	Part I	23e Did t	obacco u	ise contribute to	the cause of death?
hat th ed by letach	by P	Part II. Other significan	nt conditions con	tributing to dea	ath but not re	suiting in	ne undenyin	g cause given in	raiti.			No 3 Prot	
cords, P.C cords, P.C claw requires that e has been signed to ce 2 should be deta										24a. Was			topsy findings available
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Division of Vital Records, P.O. as or Attending Physician: The law requires that the law frequest that the law breat death. a) Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		25. Was case referred t						26.Place of Dear					
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n of ding Pb]: T	27. Manner of Death		28a. Date of Ir (Month, Day Feb 16, 20	njury (Year)	28b. Time		28c. Injury at Wo		28d. Describe Driver of SI	how inju UV tha	ry occurred t collided wit	h a tractor-trailer
On sath.	뎙	1 Natural 5 2 ✓ Accident	Pending Investigation			0212 hr		1 Yes 2	V No				
/iSi or Att ter de birect in by	<u>i</u>	3 Suicide 6		28e. Place of	Injury - At h	ome, farm,	street, factor	y, office building,	- 1	or Town.	State)		ural Route Number, City
Division To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the	Certification:	4 Homicide	determined	(Specify) N								Road, Crofto	
Hosp (2)		29a. Certifier 1 Cer	rtifying Physician:	To the best of	my knowled	ge, death	occurred at the	e time, date and	place, and	due to the cau	use(s) and e and pla	d manner as sta	ted. ne cause(s)
To the Hospital within 24 hours a To the Funeral completely filled	Medical			the basis of e manner state	xamination a	ria/or inve						Date signed (Mo	
A P 3 P 3	ž	29b. Signature and title	e of certifier				2:	O C M E	r o l			ruary 16, 20	
		famen;	withell	(m)				O.C.M.E.			l en	Tualy 10, 20	
n,		30. Name and address		pleted cause o	f death (Item	1 23a)	000.141.5	altimana Ct	of Balt	more MD	21223		
'DV		Pamela E. Sou	uthall, MD A					altimore Stre	et, Daill	mole, MD	21223		
S	tate	31. Date filed (Month, L	Day, Year)	32. Kegis	trar's Signat	U. A	acke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g925 3-2-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Month** Physician/ Hen Moore Medical 4c. County of Dea ocation of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 1 **Examiner** Baltimare Iseph Kichey If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Securation Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 70 vland 1 №M 2 🗆 F Director June 23 Mar Usual Re 10d. Inside 28a-f show 10c. City, Town or Location 10b. County 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at **Funeral Director** 1 Yes 2 □ No Maryland 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubar, Mexican, Puerto Rican, etc.) items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian. 11. Marital Status ral", or iten Examiner White, etc Black þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No If Yes, Give 3 Divorced "natural" Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Custodian Hote Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Moore ဥ Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1216 N. DuKeland St. Rolfmon, Mar 19a. Informant's Name/Relationship (Type, Print)
Dorothy Hughes -s 20b. Place of Disposition (Name of cemetery, crematory or other p - City or Town, State 20a. Method of Disposition Date Maryland 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral/Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final vascular accident Ptyllician/ erebral car disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 2-15-2012 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month in the past 12 months?
1 ☐ Yes 2 ☐ No filled in by the funeral director, page 2 should be detached for Pregnant at time of death 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DS1788 2-23-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls RA #300 Bathmore MD 21209 Polk, MD 6115 31. Date filed (Month, Day, Year) State FEB 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death Physician/ McCrea Month February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N. Bentalou Street Baltimore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months 21620 9357 Hours Country Director Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21216 Bentalou USA 1525 N 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4, or 5+) Elementary/Seconday (0-12) Balto. City Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David Edith Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Johnson Hiltonst. aaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date pemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem. PK. -3-12 4 Donation 5 Other (Specify) 21. Signature of neral Service Li ense 22. Name and Address of Facility BON P. March FH 290 Fredhillon Pass Balto mo aia29 23a. Part V. Enter the disease, or complications that caused shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death END-Stage Cardionyopa Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examiner Due to or as a consequence of if any leading to immedicause. Enter Underlying After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month Day Year 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 - No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

MS Riy apwww G 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhma MD NS Rajapt KSENID 2835 Smith MV 31. Date filed (Month, Day, Year) 32, Registrar's Signature Registrar Lessura DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylar State of Marylar Registrar		artment of Healt tificate of Deati			iene eg. No. 2	12	05541
	Physicia		1. Decedent's Name (First, Middle, Last) Winston James Miller				2. Date of Deat Februar		2012	3. Time of Death 6:00 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		1 CD1 da1	4c. County		0.00
79.5	·		207 Bay City Road		Stevensvil			Quee	n Anr	nes
	Funeral Director		5. Social Security Number 6.8 Sex 7. Age (In yrs. $1 \times 10^{-1} \text{ Ce}$) $1 \times 10^{-1} \text{ Ce}$		If Under 1 Year If Under 1 Months Days Hour	nder 24 Hrs. Irs Min.	Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign ry)
			Usual Residence of Decedent	Yrs.			Aug 24,	1920	Mary	/land
	f short	tor		ty, Town or Loc					10	0d. Inside City Limits
	28a-i	irec		evensv						1 Yes 2X No
	ith the 23a or st be r	Funeral Director	10e. Street and Number 207 Bay City Road		10f. Zip Code 21666		1	0g. Citizen of V	What Count USA	ry?
	ems ser w	nne	11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hispanic	Origin? (Spec	ify Yes or No-	14. Rac	e - America	ın Indian,
92	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give		Yes, specify Cuban, Mexi		ican, etc.)		k, White, e	
Maryland 21215-0036	ours a	Completed	3 ☑ Widowed 4 ☐ Divorced Year or Dates.		ent's Usual Occupation				White	
215	an "na Medio	mpf	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I	kind of work done during n D NOT use retired)	most of workin	g	16b. Kind of Bu	usiness/ind	ustry
212	withir giene rer th t, the		Lietheritary/Secondary (0-12)	Indu	strial Hygen	nist		Baltimo	ore C	Lty
bu	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				(First, Middle, M	laiden Sumame	e)	
<u> </u>	should be file and Mental I is marked o raumatic eve		Herman Miller	15.5			cGinn			
⊠	12 sho Ilth an 27 is r trau		19a. Informant's Name/Relationship (Type, Print) David Miller/ Son	1	g Address (Street and Nur Bay City Rd.					ode)
re,	1 and of Hea item		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of natory or other place)	_		20c. Location -		vn, State
E	Page ant: If ury or		1 25 Burial 2 El Grennation 3 El Nemova nom State		Memorial Pk.	. 2-28-	12	Baltimo	ore. N	D.
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee		Name and Address of Fa	on Fund		ne, ₂ Inc		
			23a. Part 1. Enter the disease, or complications that caused the dea	th. Do not ente						Approximate
p	h_sician/		shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition	4						Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to or as a consequence of the consequence	uence of):	1-19-1	n				
		-e	Sequentially list conditions, b.	TVC	huart f	allu	re			
	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 G	brillate	70				
	execu an and rial-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence)	uence of):						
09	death certificate be executed he attending physician and led for use as the burial-transit	edical	d. Dem	enno						
687	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregn	ancv						
Вох	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	in the past 12 months? 1 Live Birth 2 Fet 1 Ves 2 No. 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)			Mo	te of delive nth	ny Day Yea r
O :	the de by the tached	hys	g ☐ Unknown				1			
<u>Ч</u>	requires that the been signed by the should be detach	þ	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in P	Part I.				e cause of death?
rds	equire hould	eted								ably 4 Unknown
ပ	has b	Completed					24a. Was ar autops perforr	v		sy findings available apletion of cause of
ř =	in: The ificate h or, page	e Co	25. Was case referred to medical		26 Place of I	Death (Check	perform 1 Yes 2	2 No	1 Yes	2 🗌 No
VIta V	ysicia s cert direct	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2	RR/Outpatien	Othor		ne 5 Reside	nce 6 Othe	er (Specify)	
to a	ng Phy fter thi ineral	re:]	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		8d. Describe ho			
o i	tendil death. tor: A the fu	Certificate:	2 Accident Investigation		M 1 Tes 2					
Division of Vital	al or Al s after of l Direct d in by		4 Homicide determined 28e. Place of Injury - At h	ome, farm, stre	eet, factory, office	2	8f. Location (Str City or Town		er or Rural i	Route Number,
_ :	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination of the best of the bes	on and/or invest	igation, in my opinion, deatl	th occurred at t	he time, date and	d place, and due	e to the cau	se(s) and manner stated.
,	To the within To the comp.	2	29b. Signature and title of certifier	y mowedye,	29c. License number			9d. Date signed		-
			· CVI		D005	2783	3	02/2	4/2	012
1			30. Name and address of person who completed cause of death (Iter	123a) (Type, P	rint)				•	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signa	bark	/					
	negisti	ДI	FEB 2 7 2012 June S.	17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05542 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month FEBRUARY 16, 2012 Physician/ DAVIS MASON SAMUEL 8:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You Dec. 12, Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 🔀 M 2 🗆 F Director 74 215-36-2748 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Oxon Hill PG 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 2302 West Rosecroft Village Circle 20745 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. δ Maryland 21215-0036 1 Yes 2 No Specify. item 27 is marked other than "natural", other traumatic event, the Medical Exar 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Masonry Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles E. Mason Mary L. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosecroft Village Circle 2302 0xon Goldia M. Mason/wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name o 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 2/24/12 ö Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Cemetery Memorial Edwards 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hodges & 3910 Silver Hill Rd., Suitland, MD.20746 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Anoxic Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Ol Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit my and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 🗌 No 3 💢 Probably 4 🗌 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

3 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

FEB 2

una

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day, Year)

Feb, 16, 20/2

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Novris Bernard Februar 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DWSDY Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 🗆 F Director 08 Usual Resid 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21 5407 Cardina USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 MMarried Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Specify. Health and Mental Hygiene. tem 27 is marked other than "natui ther traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College,(1-4 or 5+) B. Green 10th grade Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, Maiden Surname) ျ Emerson Grace Walter Norns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Noris Cardinal Caurt Baltmare other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Wpodlawn, MD 4 Donation 5 Other (Specify) Cemetant 21. Signature of Funeral Service Licenses Vaugno C. Greene Fundral Services Randalistanh MD 2133 23a. Part 1. Enter the disease, or complice shock, or hear fallure. List only one sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): burial-transit attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 \lesssim Physician/Medical as the b IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Yes 2 No 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ◯ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate h 2 🗆 No 1 Tyes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 5 Pending 1 Natural iniury Accident
Suicide Investigation 2 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Sign 29d. Date signed (Month, Day, Year, 00071287 30. Name and address who completed cause of death (Item 23a) (Type, Print) \$4105, Balthrere 6701 N. Charles a licen FEB 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 21. 7:45 P. M Catherine Mae Nash Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3212 Chesley Avenue Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 214-03-6734 97 Director 1 🗆 M 2 💢 F March 29, 1914 Maryland show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral 3212 Cheslev Avenue 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Medical Examiner Black, White, etc. ŏ 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify: natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health ar d Menta fitem 27 is marked r other traumatic e Blanche Burton Lyman McGreevy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Madonna Road Street MD 21154 Barbara Rife/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State o = i Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Cedar Hill Cemetery 2/27/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harrior load 22. Name and Address of Facility 21. Signa e of Funeral Service Licenses Leonard J. Ruck, Inc. Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) yeur Medical Due to (or as a consequence of): Examiner History Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Tes 2 No 2 N or Attending Physician: after death. Director, After this certific To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0002769 m 6530 Walther Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 27 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State o	f Marylan		artment of tificate of		and M		')	012	05545
_			Registrar Decedent's Name (First, Middle,	Last)		Cer	incate of	Death	T	2. Date of Dea	Reg. No. —	· · · · ·	3. Time of Death
Physic		/	ARTHUR VERNON) JR					February	22, Day 201	12 Year	10:45A M
Exan	dica nine:		a. Facility Name (if not institution, Charlotte Hall Vete	give street and num	nber)		4b. City, Town Charlott		of Death			nty of Deatl	h
Funer Direct		5		6. Sex XX M 2 □ F	7. Age (In yrs. la 91	ast birthday) Yrs.	if Under 1 Yes Months Day		r 24 Hrs. Min.	8. Date of Birt 07/30/1	h 920 °)	9. Birt Mar y	thplace (State or Foreign
d d	╗.	_ 17	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits
arylan a-f sh ified a	i d	25	Maryland St Mar	v ¹ s		rlotte F							1 ☐ Yes 💥 🗓 No
the Ma or 28 e noti	غ غ	5 1	Oe. Street and Number	<u>, 3</u>	0.10	110000 1	10f. Zip Code				10g. Citizen		untry?
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r deat or iten niner r	ن	ת מ	Marital Status Never Married 2 Marr	Armed Fo		WIT 1	Was Decedent of Yes, specify Cu	ıban, Mexica	ın, Puerto F	city Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.
irs afte	7		¾X Widowed 4 □ Divorced	ied 1XX Yes If Yes, Giv Year or Da	/e	1	∣∐Yes 2 XX	No Specify	/:		Spe	cify: W	white
72 hou 72 hou 72 hou 1 "natu		nataldulon		t's Education st grade completed)		(Give	dent's Usual Occ kind of work dor O NOT use retire	e during mos	st of workir	ng	16b. Kind o	f Business	Industry
within giene.	3		Elementary/Seconday (0-12)	College (1	-4 or 5+)	1	ker_				В	anking	
Deficiency (Mary yield A. L. 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			7. Father's Name (First, Middle, L Arthur Vernon Osmo							(First, Middle, Florena			
ould b	ı,	- 1-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stre	_1	1				o Code)
and 2 st Health a em 27 is			Charles A. Osmond		Son	15844	Irish Ave	enue Mor	kton,_	Maryland			
Page 1 ar nent of He ant: If iter ury or oth		2	20a. Method of Disposition WX Burial 2 Cremation	3 Removal from	20b. F	Place of Disponentery, crer	sition (Name of natory or other p Ley Men G	place)	02/25) _{ate} /2012	20c. Locati Timoni	•	Town, State
Dalling Dermit. Page 1 Department of Important: If i any injury or or	اانه	1	4 Donation 5 ☐ Other (S		puia		-						Home Inc
permit. Departn Importa any inju	ouce.		rennes De	alen X	enak	as				ltimore,			
Physicia Medio Examin	al		23a. Part 1. Enter the disease or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complication that only one cause of a. Due to	caused the deat u.h line. as a conseq	th. Do not ente	er the mode of d	ying, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Between inset and Depth
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DIVISION Of VITAI RECORDS, P.O. BOX 00/100 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Tup Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	# C.O.O.	1	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregna Birth 2 Fet gnant at time of nown	al death 3	Ectopic pregn Other (specify				23d	. Date of de Month	livery Day Year
s that tigned b	3	y	Part II. Other significant condition	ons contributing to c	death but not res	sulting in the u	underlying cause	given in Par	t I.				o the cause of death? Probably 4 Unknown
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The lacate h			NONST	" ALVA"	Tool	MysCo	20141	IMF	Back	1 🗌 Yes	2 No	death?	s 2 🗆 No
VITAI ysician: is certifii director		io pe	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	FR/Outpatie		. Place of De Other:		me 5 Resi	dence 6 🗆	Other (Spec	cify)
of vig Phy ter this neral d			27. Manner Death 1 Natural 5 Pendir	28a. Date		28b. Time of injury	f 28c. Ir	ijury at		28d. Describe			
VISION or Attendir fler death. Virector: Af in by the ful		Certificate	2 Accident Investig	gation			M 1	Yes 2		ODS I section (Ctuant and No	mbor or Pu	ural Route Number,
I or At after of Direct			4 Homicide determ		e of Injury - At hi ling, etc. (Specif		eet, lactory, one	Je .	- 1	City or Tou		iniber or ha	nai noute Numbei,
P Hospita 124 hours Funeral		Medical	(Check 2 Medical F	Physician: To the backaminer: On the backaminer	sis of examination	on and/or inves	stigation, in my or	pinion, death	occurred at	the time, date	and place, and	d due to the	cause(s) and manner stated.
To the To the			29b. Signature and title of certifer	111	1		29c. Lice	ense number			29d. Date si	gned (Mont	h, Day, Year)
			· Cell	MI	<u> </u>	00-1 T	400	5372	C8 1	40	for	2.2	4,2012
6.			30. Name and address of person S Cafferty MD 2	who completed cau 944 % Charl o	se of death (Iter tte Hall	Road Cha	arlotte H	all MD 2	20622				
Regi	State stra		31. Date filed (Month, Day, Year)	7 2012 32.	egi stra r's Signa	A. A.	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 855 AM **Physician** RYINIA 2012 0 Q /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BAIto. MD 21212 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. 220 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic excessions. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bellona Ave. 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert V. Patrick Sr. Anne LeFaivre ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wheeley - friend 101 Mercy Dr; Belmont, NC 28012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ② Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses, Director 22. Name and Address of Facility State Anatomy Roard 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheresclerot c Physician (ard:ovasular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a nonsequence or) Physician/Medical Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed' certificate 2 1No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

32. Registrar's Signature

29c. License number

031865

Ind

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Chrua RUDY AMILCAR ROMERO PEREZ Medical County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** rince 8. Date of Birth (Month, Day, Feb 17, 6. Sex 1 Å M 2 □ F 9. Birthplace (State or Foreign If Under 1 Year If Under 4 Hrs. Social Security Numbe **Funeral** Days Hours Guatema1a Director NONE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f sho edical Examiner must be notified at Yes 2 No MD Prince George Glendale 10f. Zip Code 10a. Citizen of What Country? 10e Street and Number Funeral 20716 Guatemala 11707 Annapolis Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. à 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 Specify: Latino tx□ Yes 2 □ No Specify: Guatemalan Yes Give Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 311 Bodyshop Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o JOB ROMERO VICENTE JUANA ISIDRA PEREZ CRUZ (Brother) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Merrimac Dr Hyattsville, MD 20783 Melvin J. Romero Perez 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/4/12 San Juan Ostuncalco San Juan Ostuncalco 4 Donation 5 Other (Specify) 22. Name and Address of Facility Santa Cruz Funeral Services, Inc 21. Signature of Funeral Service Licensee 600 Kennedy ST, NW.Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final head and neck injuryes Physician/ Multide Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ned by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examinar? Other: 2 □ No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day,) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director, After 24, 121 □ Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2/300 1 Tes 2- No Investigation Accident the 28f. Location (Street and Number or Tural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:15 P^{M} February Powel1 Edward Α. . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's 102 Tackle Circle Chester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 213-26-1294 (Month, Day, Year) Director 79 1 JM 2 F May18,1932 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State notified at Director Md. Oueen Anne's Chester 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 102 Tackle Circle 21619-0306 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. 0 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 'natural", Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Salesman</u> Automobile 8th Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hymportant: If item 27 is more any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) (unk) ပ Lucille Frank Szczuchowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 306 Chester, Maryland 21614 Linda Bosley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Febrüäry 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 28, 2012 Baltimore, Maryland MO1259 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Fundamental icensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CONCAUSIN disease or condition Medical resulting in death) 13 years **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal deal
Pregnant at time of death in the past 12 months? been signed by the a should be detached t g . Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To Be Completed fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has l autopsy performed? Yes 2 X No death?
1 Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 5 Pending 1 🔀 Natural Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Exertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign re and title of certifier 29d. Date signed (Month, Day, Year) R 082434 February 23, 2012 (Item 23a) (Type, Print)

P 125 Shoneway Drive Suite 120 Queenstommo 21458

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryl		artment of H <i>rtificate of D</i>			giene Reg. No. 2 (112	05549
	Physicia		1. Decedent's Name (First, Middle, Las.					2. Date of Dea		Year 7	3. Time of Death M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or		0 -0	4c. County		
	Funeral		Season's Hospice 5. Social Security Number 6. Se		rs. last birthday)	Randall If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h -	9. Birthpl	ace (State or Foreign
L	Director		215-64-4478 Usual Residence of Decedent	□ M 2 🔯 F	58 Yrs.	Months	Hours Will.	Oct.14		Mary	
	yland f show ed at	ctor	10a. State 10b. County MD Baltin		City, Town or Lo	ocation				10	od. Inside City Limits 1 ☐ Yes 2 ^X No
	the Mar or 28a e notifi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	
	ms 23a must b	Funeral	1230 Brewster Str	12. Was Decedent Ever in	1118 13	21227 Was Decedent of His	enanic Origin? (Spe	ecify Yes or No-	USA	ce - America	ın İndian
980	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2√√ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2x XNo If Yes, Give Year or Dates.		If Yes, specify Cubar 1 ☐ Yes 2 ★No	n, Mexican, Puerto	Rican, etc.)	Bla	ck, White, e	tc.
15-0	72 hou in "natu Medica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual Occupa kind of work done do DO NOT use retired)		ing	16b. Kind of E	Business/Ind	ustry
212	d within ygiene.	Be Cor	Elementary/Secondary (0-12)	College (1-4 or 5+)		retery					Contracting
land	should be filed within 7; and Mental Hygiene. is marked other than aumatic event, the Me	70 B	17. Father's Name (First, Middle, Last) Robert Henry Keys				18. Mother's Nam	- ' '		,	
Jary			19a. Informant's Name/Relationship (Ty George Rodgers /			ing Address (Street a					ode)
Baltimore, Maryland 21215-0036	1 and 2 of Health item 27 other tr		20a. Method of Disposition	20	b. Place of Disp	osition (Name of ematory or other place		Date	20c. Location		vn, State
timo	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) <u>M</u>	eadowrio	lge Mem.Pa	rk Feb.	27,2012	Elkrid	ge, M)
Ba	Depar Impor any ir		21. Signalul of Funeral Service Licens	theone		2. Name and Addres					
Ī			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of			ter the mode of dying	, such as cardiac	_			Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Over Due to (or as a cons	sequence of):	Can	ce			- 4	Shoot and Boath
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con:	seguence off:						
Y.	uted nd ransit	Examiner	Cause (Disease or injury that initiated events	c						V	
5	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a con:	sequence of):						
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. Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	У			ate of delive onth	ry Day Year
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a B	ding Physician; The law h. After this certificate has funeral director, page 2	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec	1 U Yes	2 No	1 Yes	2 No
f Vit	Physici this cer ral direc	욘	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of injury	2 ER/Outpatie		4 Nursing H	ome 5 Resid			pice
o uo	ending eath. rr: After he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea		work'		Zed. Describe i	low Injury occur	Teu	ne stance
Division of Vital Records,	al or Attendi s after death I Director: A ed in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, st ecify)	treet, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	ber or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical	(Check 2/ Medical Exami	ician: To the best of my kiner: On the basis of examine Practitioner: To the best	ation and/or inve	stigation, in my opinio	n, death occurred a	t the time, date a	and place, and di	ue to the cau	se(s) and manner stated.
_	To the within Comp	-	29b. Signature and title of certifier	\sim	mo	29c. License		7 +	29d. Date signe		
	0,		30. Name and address of person who d	ompleted cause of death	Item 23a) (Type,	Print)	30/0	<u> </u>	01	12	21061
	\		31. Date filed (Month, Day, Year)	32. Regi s trar's Si	Anature P	He, at	s'h s	kor o	rens	SURB!	106/
	Sta Registr		FEB 2 7 2012 2	32. Registrar's Si	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 1 - State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 23,2012 1:45p M Janina Robak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Baltimore Co. Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Director 218-30-5057 1 □ M 2 🔀 F 90 1-20-1922 Poland Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? be r items 23a oner must be Completed by Funeral 21224 USA 624 S. Montford Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status event, the Medical Examiner Armed Forces? Black, White, etc. 9 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Peter Suwala Maria Zak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important If item 27 is any injury or other transconce 5619 Hawthorne Street Cheverly, MD 20785 Casimir Robak - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 2-28-12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility aczorowski Funeral Home, PA Signature of Funeral Society Cense 1201 Dundalk Avenue Baltimore, MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as the burial-trar Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Voai Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) **HOSPICE** 2 🗶 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical within 24 hou

To the Fune

completely fi 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 3 37

DHMH 17 Rev 06-2011

State Registrar

2012

FEBRUARY 23,

JANINA ROBAK

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

TARIQ MAHMOOD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{1}3$ Month February 2012 Cyrus Francis Sanders 12:47 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Household of Angels Assisted Living Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) Director 304-14-4486 93 1X M 2 D F Usual Residence of Decedent March 30, 1918 Indiana ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Arundel Beach Rd. 21146 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 19 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1941 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 1945 Completed 3 XWidowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 truck mechanic automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of O. Huston Sanders Winnie Pearl Ghere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Susan Mason - friend 1811 Bayside Beach Rd; Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of uneral Service Vicenses 22. Name and Address of Facility State Anatomy Board Ronald S 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, othean failure. List only one cause on each line. Interval Between Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALZHEIMER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) MYS13TED Other: 1 ☐ Yes 2 X No LIVING ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State

Box 68760 P.0. Division of Vital

> State Registrar

completely

Medical

29a. Certifier

(Check

FEB 27

3100 LOAD BALTIMORE DR #110 BALTIMORE, MD 21244 RAYNOLD DEPESTRE

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practifing Nurse Practification (Nurse Practification Nurse Prac

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Janet SMITH 11:59AM February 2012 Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltin Son 405 town 06-6 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Min (Month, Day, 7-50-2853 Director 1 🗆 M 2 🗶 F 62 9 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland by Funeral Director notified 1 Yes 2 □ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be USA 21218 unnea Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?.

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No "natural" Completed 3 Widowed 4 Divorced Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working Baltimore County er than life. DO NOT use retired) College (1=4 or,5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Police Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ္ omas hornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu ber or Rural Route Number, City or Town, State, Zip Code) Son taron Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) crematory or other nia Kandallstown, ning March F/H-East 1101 E. North Signature of Funeral Service Licensee 22. Name and Address of Facility Ba 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 98 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) bed ! the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 Yes 2 No 3. Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 has certificate 1 Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) in rationt hospice Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Othe within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident completely filled in by the Sulcide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Ry apalm M.O D0057465 2123/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S-RWAPAXSE, M.D. 2835 Smin Av Baltimore MD 21209

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2

7 2012

32. Registrar's Signature

12-00560 Mary Samone

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

flary Samone		- For State Registrar	Stat	e of Mary	land / [rtment of <i>tificate of</i>			i Menta	al Hyg		eg. No.	201	2 0555	
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		4a. Facility Name (if not inst 645 S. Lehigh Stre		give street and r	number)		[Baltiı		Location of	Deau		40.	County of Dea	uı	
Funeral	٦	5. Social Security Number L		Sex	7. Age (I	n yrs. la	ıst birthday)	If Und	der 1 Year	If Under	24Hrs.	8. Date of Birt	th(MM/D	DD/YYYY) 9. B	irthplace (State or Unit	
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2 5 6 5 g s		19a. Informant's Name/Rela	ionship	(Type, Print)			19b. Mailing	Addres	s (Street	and Numb	er or Rur	al Route Num	ber, Cit	y or Town, Stat	te, Zip Code)	
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		30. Name and address of pe Carol Allan, MD		no completed ca stant Medica		_	23a) 900 W. Bali	timore	Street, I	Baltimor	re, MD	21223				
Sta	te	31. Date filed (Month, Day, Y	ear)	∌ 32. F	Registrar's	Signatur		,								
Registr	ar	FFR 2.72	012	Bereit	a A	1 1	barke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** es 06 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F Director 038-26-7748 70 Dec 23, 1941 Rhode Island Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1X Yes 2 No be notified Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 21214 4700 Harford Rd. items 23a Examiner must Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No unk If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: black Maryland 21215-0036 'natural", or 1 ☐ Yes 2X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Maryland School for Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) unk the Blind unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; if item 27 is any injury or other trau Pastor Baylor - friend Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Si mate of Funeral Service icens 22. Name and Address of Facility State Anatomy Board konali 655 W. Batltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus , n each line. Approximate Interval Between Onset and Death Hero sclentie Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner eronar ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ence of) burial-transit as a conse uence of): Box 68760, attending physician I for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 □ Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 4 Unknown 1 TYes 2 No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? (es 2 2 No 1∐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient P 27. Man r of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Year

2000

de

2. Registrar's Signature

12-01603 Stephanie Sargent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	-	2	0	5	5	5	100

	F	For State Certificate of Death Reg. No.
Physiciai Medical Examin	n/	Decedent's Name (First, Middle,Last) Stephanie Sargent 2. Date of Death Month Day Year February 24, 2012 3. Time of Death 0553 hrs
		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital 4c. County of Death Baltimore
Funeral Director		Social Security Number 6. Sex 1 Months 23 Yrs. Social Security Number 536-23-4623 1 Months 5 Months 6
daryland 28a-f sbow any 1.at once,	Ī	Sual Residence of Decedent Oa. State
death with the Maryland rr items 23a or 28a-f sho must be notified at once.	Director	Oe. Street and Number 24 E. Mt. Vernon Pl. Apt 3 10f. Zip Code 21202 USA
ufter death witi 117, nr items 2 ner must be n	Fulle	1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Was Decedent Ever in U.S. Armed Forces? 1. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Yes 2 X No specify:
6 172 hour na "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CIS Assistant 16b. Kind of Business/Industry Homeland Security
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked niher than matic event, the Median	Be	7. Father's Name (First, Middle, Last) Jack W. Sargent 18. Mother's Name (First, Middle, Maiden Surname) Linda R. Rice
MD 21 dd 2 should lith and Me m 27 is ma	_[Pa. Informant's Name/Relationship (Type, Print) Tack W. Sargent / Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other fram		Da. Method of Disposition Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify: Date 20c. Location - City or Town, State of Disposition (Name of cemetery, Crematory of other place) W. Arundel Crematory Odenton, MD
		1. Signature of Funeral Service Licensee M01452 M01
Physician Wedical Examiner	1	Approximate Interval failure. List only one cause on each line. Interdict Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Death Death Death
	ner	equentially list conditions, annual content of the conditions and the conditions and the conditions are consequence of the conditions and the conditions are consequence of the conditions are conditions are conditions are consequence of the conditions are conditions are conditionally are cond
uted ud ansit	Exam	vents resulting in death) Last Due to (or as a consequence of): d.
760, icate be executed physician and the burial - transit	edical	UNPENDED AMENDED SEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 6876 death certificat the attending phy of for use as the		FEMALE: b. Was decedent pregnant in the past 12 months? Yes 2 No 9 V Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
res that the d signed by the be detached	2	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown
Records The law requi	Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page	8	5. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other:
on of Vicending Physicath. or: After this the funeral dir	tion: To	7. Manner of Death 1 Natural 5 Pending PolyNith: Day, Year) FOUND: 1 Yes 2 No Subject precipitated from window
Division of voptial or Attending Ph. hours agter death.	Certification:	28. Place of Injury - At home, farm, street, factory, office building, etc. 38. Suicide 6 Could not be determined (Specify) Multi-Family Apt. 28. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 27. E. Mount Vernon Place , Baltimore, MD
To the Hos within 24 hd To the Fun completely	Medical (9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Me	9b. Signature and title of certifier 29c. License number O.C.M.E. OGNE 29d. Date signed (Month, Day, Year) February 25, 2012
4		o. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Sta Registr		1. Date filed (Month, Day, Year) 32. Registral's Signature 8. Saulus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Acosewaa Jabulani Sarudzi Smith February 5:58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Howard Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Hours Min. April 2 1 🗆 M 2 🗓 F 1970 Washington DC 41 Yrs Director 220-92-6756 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ıral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director 1 🗆 Yes 2 🎖 No Howard MD Elkridge 10e, Street and Number 10f. Zip Code 21075 Funeral 5885 Whisper Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exa Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) nursing aide healthcare Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ronald Earl Haywood Karen Yvonne Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5885 Whisper Way; Elkridge, MD 21075 Kenneth Smith - brother Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 X Donation 5 - 9ther (Specify) Sign tunof Funeral ervice 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Endometria ears disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter chaerlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events sician and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No j Month Day Year Pregnant at time of death P.O. signed by the betach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🗹 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 1 Natural 5 \square Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

EDAR

Registrar's Signature

LANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

336

00060634

COLUMBIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2012 Emma Patricia Shilling FEBRUAL. 0600P 20 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Death ANNE ARUNDE BALTIMORE INASHINGTON MEDICAL 9. Birthplace (State or Foreign Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 218-07-6760 93 **Director** 1 M 2XX Nov.6,1918 Maryland Usual Residence of Dec items 23a or 28a-f show her must be notified at Oa. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lansdowne 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 2406 Alma Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status ian "natural", or ite Medical Examiner Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No SHUNG, EMM A Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) q 0 Clothing <u>Presser</u> and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lydia Pauline Pfeiffer Edward McKee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any Gloria Warfield / Daughter 152 Clyde Avenue Lansdowne, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Meadowridge Mem.Park Feb. 24, 2012 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MON FNF disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year the be detached 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed Yes 2 certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ✓ Inpatient 2 □ ဂ္ ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Date signed (Month, Day, Year) th (Item 23a) (Type, and address of person who comple

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D1^y6, 2012 Feb. Physician/ 10:10 PM Richard Wayne Sickle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 7970 Oakwood Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F **Funeral** Sept. Day, Year 54 Mar VI and 214-62-5920 57Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a State 10c City Town or Location Director 1 Yes 2 X No Maryland | Baltimore Halethorpe 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 3129 Freeway 21227 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12, Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Depot Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Katherine Herlth William Paul Sickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7970 Oakwood Road, Glen Burnie, Maryland 21061 Katerina Leary / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Feb. 18,2012 Glen Burnie,Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Dineral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME.INC. alu 328 Sulphur Spring Road, Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final COLON CANCER Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 1 Yes 2 No ed by the a P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has performed? Yes 2 N After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Daughter Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. work? 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af completed filled in by the fur 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

3*1

Medical

29a, Certifier (Check

only one)

Date filed (Month,

29b. Signature and tile of certifier

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EW COLE STAGNES 900 CATO

Registrar DHMH 17 Rev 7/2009

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

16354

900 CATON AVE BALTIMORE MD

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 February 4:15 PMM Scott Medical Geraldine 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll <u>4236 Francis Scott Key Highway</u> <u>Taneytown</u> If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 218-28-4000 1 □ M 2 🛛 F 80 Yrs. 12/16/1931 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 1 Yes 2X No Carroll Taneytown Maryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? "natural", or items 23a o Funeral U. S. A. 21787 4236 Francis Scott Key Highway 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XXNo Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: 3 - Widowed 4 - Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Billing Clerk Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မှ William Julia Gertrude Hogan Frank Bryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21787 19a. Informant's Name/Relationship (Type, Print) of Health a Billy Lee Scott, Sr. (Husband) 4236 Francis Scott Key Highway Taneytown, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once, Holly Hill Mem. Gard. 2/29/2012 Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdziński Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 10 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed this certificate Yes 2 🔽 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 400 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director; After or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D71040 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6701 NCHARLES ARATHT SUTTE

DHMH 17 Rev 06-2011

Registrar

ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&19a &B per ANA BD G924 2/2//2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ F_M Medical institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SILVER IN G MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Min. O Month Day. Hours Texas **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No KENSINGTON MONTGOMERY 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3000 MCCOMAS 0895 NSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced Specify: WHITE Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NHN unk unk UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gordon Tatum UNK 19a Informant's Name/Relationship (Type, Print)
Tripp Tatum—son 19b 19608 de Ga Tway d Barber Cferel #402 mbe Germantown Zio MD 20874 permit. Page 1 and 2 st Department of Health a Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 N Other Specify) In State cemetery, crematory or other place) ure of Funeral Service License Ronald S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ numona day Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): g physician a Physician/Medical Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ excbrovascular accident Records, 3 Probably 4 Unknown 2 No as been signal Completed dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page pertension 1 Yes 2 No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 **N**o Other: မှ 1 🗌 Yes 1 Inpatient 2 TER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 043121 howdy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 605 Main St, Laurel WDHURY, MD; 32. Registrar's Sig State Registrar

Michael 10505 Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-01398 2012 0556 State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ February 16, 2012 1648 hrs Medical Examiner Michael Toscos, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore 1830 Wilhelm Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director Countryland August 25,1972 212-90-9858 1 X M 2 F 39 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 No Baltimore City Maryland 23a or 28a-f show notified at once. hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21230 1631 Sexton St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: White 5 1 Yes 2 No specify: 4 Divorced If Yes, Give Year 2 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 hort of Health and Mental Hygiene.

ant: If item 27 is marked other than "u
or other traumatic event, the Medical E. Unemployed Baltimore, MD 21215-0036 Unemployed 0 7 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael R. Toscos

19a. Informant's Name/Relationship (Type, Print) Dorothy Mae Painter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 1631 Sexton St., Baltimore, Maryland 21230 Michael R. Toscos, Sr. / Father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 X Burial 2 Cremation 3 Removal from State Department of Feb. 23, 2012 Brooklyn Park, Maryland Cedar Hill Cemetery 4 Donation 5 Other Specify: Signalure of Funeral Service Licenses AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 2122. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Wedical Death a Narcotic (Heroin) Intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a, 27, 28a-f, per me, g925 3-1-12 sm Physician/Medical signed by the attending physician be detached for use as the burial -X UNPENDED The law requires that the death certificate be Box 68760, 23d Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Fetal death 3 Ectopic pregnancy Day Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. P.O. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an After this certificate has been to funeral director, page 2 should prior to completion of cause of death? autopsy performed? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: ' 25. Was case referred to medical æ examiner? Other, Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Director: After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 1 Yes 2 X No unknown Division 5 Pending fd 2-16-12 fd 1640 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1830 Wihelm St. Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide other determined (Specify) 4 __ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 17, 2012 O.C.M.E.

Registrar

Zabiullah Ali, M.D. FEB 2 7 2012

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signatur

Assistant Medical Examiner

State

900 W. Baltimore Street, Baltimore, MD 21223

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George B. Tymus			of Maryland					ental Hy	giene	201	2 000
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	h	21. Signature of Funeral Service Licer								me of Mary	and
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Physician	ヿ	23a. Part I. Enter the disease, or comp	olications that caused	the death.	Do not er	nter the mode of	of dying, such a	as cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval
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ox 6 eath cert attendii	흥		4 Pregnant at	time of dea	ath 5	Other (Spec	cify)			**/	
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical		r:On the basis of exa							and place, and due to the	
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0		Name and address of person who Theodore M. King, Jr., MI				er 900 W	Baltimore :	Street. Bal	timore. MD	21223	
		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re .		-a.a				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g925 3-2-12 vt State of Maryland / Department of Health and Mental Hygiene 2 | | 2 State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) February 19:45 PM 23 Zear 12 100N Physician/ Medical City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number Examiner N/A Baltimore HOPKINS HOSPITA Johns Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 243-54-0828 7/26/1939 N.C. 1 X M 2 🗆 F Director 72 10d. Inside City Limits 28a-f show 10c. City, Town or Location notified at Director 1 X Yes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö ms 23a or must be r Funeral 21218 USA 2643 Kennedy Ave. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō Completed by 1 ☐ Yes 2 💢 No Specify: Specify: Black Baltimore, Maryland 21215-0036 "natural" 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working Medical 15. Decedent's Education (Specify only highest grade completed) Russell life DO NOT use retired) is marked other than aumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) R&H Motors A/N12th 18. Mother's Name (First, Middle, Maiden Surname, Be unkwn 17. Father's Name (First, Middle, Last) Mabell Toon မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 403 E. Coldspring Ln. Baltimore, MD 21212 Versia M. Toon-Wife item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State $3/\frac{2}{2}$ 2012 Randallstown, MD King Memorial Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H-East 1101 E. Signature of Funeral Service Licensee North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CONGEST Physician/ Medical resulting in death) cardiomyorathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Tetal death Day Year in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manner of Death Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after deat To the Funeral Director. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification RES- 600 600 North Wolte St, Battimore, MD, 2128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRNEL 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARIES 9120A M Homas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death College Place eniors Hark If Under 1 Year If Under 24 Hrs. , Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 78-64-3518 1 M 2 D F Min (Month, Day, Director 65 -1947 WOSH, D.C Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medic I Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No am TEMPLE Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7307 JSA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 TH Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -lack 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samella WESSEX Dr. Temple Hills, MD., 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Harmony Memorial Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee Funeral Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final izheimers Onset and Death Physician. disease or condition resulting in death) INKNOWN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 2 🗌 No Yes 2 No 1 Yes 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending 2 | No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and tit 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 2012 February 10 3:00 Karen Anne Vogel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 1806 Oriole Way Leonard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 62 Director 263-92-8847 1 □ M 2 🗓 F 1950 Florida Jan 17, Usual Residence of Decedent should be filed within 72 hours and and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f show it marked other than "hatural", or items 25a or 28a-f show if is marked other than "hatural", or items 23a or 28a-f show if it marked other than "hatural" or items 23a or 28a-f show in marked other than "hatural". 10c. City, Town or Location 10d. Inside City Limits Director St. Leonard 1 ☐ Yes 2X No Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20685 USA 1806 Oriole Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1 Yes 2X No Specify white 3 Widowed 4X Divorced Completed Year or Dates unk 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) bookkeeper n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Betty Mae Voss Edward Karl Vogel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1806 Oriole Way; St. Leonard, MD 20685 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 strength of Health a Kellie Lynch - daughter 27 Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of netery, crematory or other place) injury or 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 25. Was case referred to medical Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 TOther (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Natural work?
1 Yes 5 Pending 2 No Accident Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопретену (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated tre and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BANNE

FEB 2 7 2012

31. Date filed (Month, Day, Year,

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

238

Merrima

MI

12-01464

Millissa Marie Vandegrift

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar Certificate of Death Reg. No.											
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Millissa Marie Vandegrift					2. Date of Dea Month February	Day Year	3. Time of Death 0830 hrs				
		4a. Facility Name (if not institution, give street and number) 516 Maryland Avenue		4	b. City, Town, or Cumberland		eath	4c. County of Allegany	Death				
Funeral Director		195-54-1962 _{1□M 2∑F} .	In yrs. last birt 37	hday) Yrs.	If Under 1 Yea Months Day		4Hrs. 8. Date of Bir Min. 08/30	th(MM/DD/YYYY) /1974	9. Birthplace (State or Foreign Country) NJ				
Maryland 28a-f show any d at once,	or		c. City, Town Cumber		on				10d. Inside City Limits 1 XXYes 2 No				
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 516 Maryland Ave.		·	10f, Zip Code 21502		1	0g. Citizen of Wha	at Country?				
9 2 3	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 1 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comple	No No	If Y∈		n, Mexican, Pu specify:	(Specify Yes or No lerto Rican, etc.)	14. Race - White, Specify:	White				
036 ithin 72 hounder. The control of	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			st of working life			Trade (
MD 21215-0036 dd 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than a market other than a market other than a market event, the Medica	B	17. Father's Name (First, Middle, Last) Joseph Vandegriff				Marle		ams					
MD 2' id 2 should ilth and M m 27 is ma	٩	19a. Informant's Name/Relationship (Type, Print) Fred Vandegriff / Brother	14	423 F	larmony	Ridge I	or Rural Route Nun	ore, PA	17518				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	cremate	ory or oth Cren	nation S	vc. 02	Date 2/25/2012	Leola,					
		21. Signature of Funeral Service Licensee M0145		Bai 402	ley Fun 3 Annap	eral Ho olis Ro	ome and C d., Halet	remation horpe, M	Svc. PA 21227				
Physician Wedical Examiner		Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Endocarditi		t enter th	e mode of dying,	such as cardi	ac or respiratory arr	est, snock, or near	t Approximate Interval Between Onset and Death				
		or condition resulting in death) Due to (or as a consequence by Chronic Drugs) Due to (or as a consequence by Chronic Drugs)	ug Use										
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exents resulting in death). Last				_							
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence of the constant of		or m	a a025 3	2_15_12	Cm						
8760, tificate be en physicial as the buria	Medical	IF FEMALE: 23c. If yes, outcome of				7-13-12	. sm	23d. Date of d	elivery				
Box 6876 e death certificat the attending phy ed for use as the	21	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time	2		al death 3 [er (Specify)	Ectopic pre	egnancy	Month	Day Year				
P.O. Box 68 sthat the death certiful med by the attending edetached for use as	Physicia	1 Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to death bu	ut not resulting	j in the ur	derlying cause g	jiven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?				
ds, P.O quires that then signed by the detaction	ted by		-			-	1 Yes		Probably 4 Unknown ere autopsy findings available				
tal Records, cian: The law requirectificate has been sector, page 2 should	Completed					<u> </u>	autop perfor 1 ✔ Yes	med? de	ior to completion of cause of ath? Yes 2 No				
Vital Recysician: The Ihis certificate Idirector, page	Be C	25. Was case referred to medical examiner?				of Death (Che	eck only one)						
Physic r this	ᇍ	1 ✓ Yes 2 No		tpatient				Residence 6					
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should b	ation:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	280. 1	Fime of In	· · I _ ·	ry at Work? res 2 No	28d. Describe r	now injury occurred	d .				
Divis	Certification:	3 Suicide 6 Could not be determined (Socify)	- At home, fa	rm, street	, factory, office b	uilding, etc.	28f. Location (S or Town, S		or Rural Route Number, City				
	Medical	29a. Certifier (Check only one) 2 Medical Examiner. On the basis of examinating and manner stated.	nowledge, dea ation and/or in	th occurre	ed at the time, da	ate and place, , death occurre	and due to the caus ed at the time, date	e(s) and manner a and place, and du	e to the cause(s)				
	Ž	29b. Signature and title of certifier			29c. Licens O.C.I			29d. Date signed February 20	d (Month, Day, Year) , 2012				
OCME		30. Name and address of person who completed cause of death Mary G. Ripple MD. Deputy Chief Medical		900	W. Baltimore	Street, Ba	altimore, MD 21	223					
Sta Registi	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	fa	Red			-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 06.379 Month Year Physician/ SEPH WHEE FEBRUARY 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** NA TIMORE MEDSTAR HARBOR HOIPITAL 8. Date of Birth (Month, Day, Year) Mar 5, 1951 Birthplace (State or Foreign Country)
 SC 7. Age (In yrs. last birthday) **Funeral** SC 1 M 2 D F 60 216-54-8431 Director 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County at Director 1 Yes 2 No be notified **Baltimore Baltimore City** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 U.S.A. 23a Funeral 2821 Kinsey Avenue Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1. Marital Status Armed Force Black, White, etc þ 2 X No 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify Black If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than, life. DO NOT use retired) should be filed within 7 h and Mental Hygiene.
7 is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Disabled Disabled 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Queenie Wheeler Joseph Wheeler Sr. permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2821 Kinsey Avenue Baltimore, MD 21223 Queenie Wheeler 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Lansdowne, Maryland Feb 25, 2012 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each li Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or s a consequence of) as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown q 🗌 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has death? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \(6 \subseteq \text{Other} \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ . Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 27. Manner of Death Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 2 Accident the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDEZ DO

RES-001

16,2012

FEBRUARY

DUBRTE, 3001 SOUTH HANOVER ST, BALTIMORE, MD, 21225

		for State Registrar	***			d / Depa	artment of I tificate of L	Health		/lental Hy		ne 2 N	12	05568
Physiciar Medica Examine	al	Decedent's Name (First, Elizabeth 4a. Facility Name (if not ins)	,	reet and numb	per)	Wi	1kins 4b. City, Town, o	r Location	of Death	2. Date of De Month 02	21	Day 20 4c. County		3. Time of Death 12:46 p ^M
		12502 Cleary	vater W	ay			Upper M	ar1bo	ro			Prince	Geo	
Funeral Director		5. Social Security Number 578-22-5910 Usual Residence of Dece		M 2 XF	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 6/24/1	y, Yea	9. Birthplace (State or Foreign Country) WASHINGTON, DC		
28a-f shov otified at	irector		one			y, Town or Loc hingto							1	0d. Inside City Limits 1 X Yes 2 □ No
ns 23a or must be n	Funeral Director	10e. Street and Number 3316 Blaine					10f. Zip Code 20019				<u>USA</u>	Citizen of W	/hat Cour	ntry?
ral", or iter Examiner		11. Marital Status 1 Never Married 2 3 Widowed 4 D	☐ Married	Armed Ford Armed Ford 1 Yes If Yes, Give Year or Dat	2 XNo	. 1	Was Decedent of H f Yes, specify Cuba □ Yes 2 X No	an, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		Black	- Americ , White, of Blac	
Department or Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by		Decedent's Edu ly highest grad (0-12)	cation		(Give I life. D	dent's Usual Occup kind of work done of O NOT use retired)	during mos	st of work	ing		. Kind of Bu		
ked other i	To Be C	17. Father's Name (First, M James Arthu	liddle, Last)	7		Super	VISOF			e (First, Middle, V. Wait	Maide			ernment
alth and Me 127 is marl er traumati		19a. Informant's Name/Re Karen Johns				1	ng Address (Street				-			
ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5 C	mation 3 🗆 F		State C	emetery, cren	sition (Name of natory or other place emorial 1			Date / 2012		. Location -	•	
Import any inji		21. Signature of Funeral So	ervice Licensed	egler	ial	22	Name and Addre	ss of Facili	ty Man	rshall-	Mar	ch Fu	nera	
rsician/ Medical aminer	Examiner	23a. Part 1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying	e. List only one	Alzh Due to (c	aused the deat th line. Leimer' or as a consequence as a	s Dise	,	ig, such as	cardiac c	or respiratory ar	rest,			Approximate Interval Between Onset and Death
siciar	cal	Gause (Disease of Injury that initiated events resulting in death) Last		Due to (d	or as a consequ	uence of):								
within 2+ hous are locari. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	uit I	1 🔲 Live E	ome of pregna tirth 2 Feta ant at time of o own	aldeath 3	Ectopic pregnand Other (specify)	су				23d. Date Mor	e of delive	ery Day Year
n signed by	کر ا	Part II. Other significant of	conditions con	tributing to de	ath but not res	ulting in the u	nderlying cause gi	ven in Part	1.					ne cause of death?
te has bee bage 2 shor	Completed									24a. Was auto perfo 1 \sum Yes	psy ormed	? p		osy findings available mpletion of cause of
ector, p	Be	25. Was case referred to mexaminer?	⊢	ospital:			1	lace of Dea		k only one)				_
After this c	sate: To		Pending	1 🔲 1 28a. Date o	npatient 2 f injury n, Day, Year)	ER/Outpatier 28b. Time of injury	28c. Injur work	y at		ome 5 Resident Resident Part 28d. Describe h				er's Home
Director:	Certificate	3 Suicide 6 🗆	Investigation Could not be determined		of Injury - At ho g, etc. (Specify	arm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
the Funera	Medical	(Check 2 ☐ Me	dical Examine	er: On the basis	s of examination	n and/or invest	occurred at the time tigation, in my opinie death occurred at t	on, death o	ccurred at	the time, date a	and pla	ace, and due	to the cau	use(s) and manner state
Tot	_	296. Signature and file of	centifier	1	2		29c. Licenso D 130	e number			29d. l	Date signed	(Month, L	
5		30. Name and address of p Stephen M. S		1160 \	of death (Item Varnum	Street		ingto	n, D	C #311	200)17		
State	е	31. Date filed (Month, Day,	Year)	32. Re	strar's Sana	urag /								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 958AN Physician/ WALLACE 26 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1736 Homestead Street **Baltimore** NA 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) Director 1 □ M 2 🕇 F 213-30-2217 78 MD Mar 6, 1933 Usual Residence of Deced 28a-f show with the Maryland notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code Examiner must be items 23a Funeral 1736 Homestead Street 21218 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Daycare Provider** 12 **Davcare** Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ William Eades Marie Eades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Smith 3905 Southern Cross Drive Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 27, 2012 Mt. Zion Cemetery Lansdowne, MD Signature of Faneral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. ALL 1300' Futaw Place Baltimore, Md 21217 23a. Fart 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Kithe disease or condition Medical resulting in death) Due to (or as a cons Juence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Litter of ucrying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and -trar Due to (or as a consequence of): resulting in death) Last the burial Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year q Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 2 🗌 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 2 🔀 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Tes 2 🗀 No Accident Investigation
6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the be st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of

State Registrar ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND TIEM#10c, perFH, G924, 2/27/2012, wS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 0557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:50 PM Kenneth Wise February 22 ,2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-7-1957 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Yrs 54 Director MD Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1√ Yes 2 □ No Director Chase St. Baltimore 1915 E. MD 10e. Street and Number 10f. Zip-Code 10g Citizen of What Country? Chase Street

12. Was Decedent Ever in U.S. Armed Forces?

1 — Yes 2 Tho If Yes, Give Year or Dates: Funeral 1915 E. 21213 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: þ Specify Black 3. Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tailor Clothing Master traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic evance. marked John Wilson Wise Ethel Mary Tibbs မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 E. Chase St. Balto. MD 21213 Kyle C. Gregory-Wise 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Donation 5 Other (Specify) Stanislaus 3-3-2012 Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Phillip A. Weatherford, FS, F 2431 E. Oliver St. Balto, MD shock, or heart failure. List only one cause on each line. Phillip A. Weatherford, FS, PA Approximate
Interval Between
Onset and Death immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 Tes 2 □ No the certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Acute Benad Fadure 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Circhosis autopsy performed? Yes 2 No Acute Respiratory Syndrome Distress 1 TYes 1 Yes 2 🗆 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation vithin 24 hours area ...

To the Funeral Director: After a funeral birector of the funeral birector. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar Satish

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

RES-000

February 22,2012

4940 Eastern Avenue, Baltimore, MD, 21224

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Misca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 22, 2012 Physician/ 11:10P GLADYS WOOLFORD WINTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** None Baltimore 16 Roland Mews If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 202-18-5972 1 - M 2 XXF 88 **Director** 09/14/1923 Maryland Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director YY Yes 2 No Maryland None Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21210 USA 16 Roland Mews Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: If Yes, Give 3XXWidowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Volunteer Community permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Woolford Milton Leila 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DTR 7808 Overbrook Road Towson, Maryland 21204 Anne Winter West 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State 02/24/2012 GreenMount Crematory Baltimore, Maryland UD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 40years Examiner Cigarette Equirations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Gastroenteritis (viral 1XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: s after death. work?
1 🗌 Yes 2 🗆 No 1 X Natural 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours a To the Funeral D To the Hospital

> State Registrar

DHMH 17 Rev 06-2011

29a, Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day; Year)

David D. Collins md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles St., Suite 4101

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

020650

29d. Date signed (Month, Day, Year)

Feb. 23, 2012

Balto, MD 21284

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:52 A^{M} February Donna Christina Zepp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie 1006 Somerset Dr. If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 62 218-52-3305 Director 1 □ M 2 🛣 F 10. <u>April</u> 1949 West Virginia Usual Residence of Decedent show 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State with the Maryland Director 1 ☐ Yes 2X☐ No Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21061 1006 Somerset Dr. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces 2 Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) aviation ground service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Juanita Jennings Robert Elwood Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Somerset Dr; Glen Burnie, MD 21061 Albert Zepp - husband t of Hea 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 X Donation 5 Other (Specify) WWW I 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

k, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ dua disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Take to for any a consecutional of Exami signed by the attending physician and de detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death 1 Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed ieral Director: After this certificate has been si filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔁 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the 3 the only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

305

29d. Date signed (Month, Day, Year)

2012

DHMH 17 Rev 06-2011

State Registrar TRACIE L.

Date filed (Month, Day, Year)

MORGAN,

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Day Year David Howard Austein 2012 10:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 8-26-1950 61 Yrs. Director 157-38-6575 Germany Usual Residence of Decedent 28a-f shov ms 23a or 28a-f short must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14609 Brougham Way United States 20878 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Pediatrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. traumatic Max Austein Pearl Sens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Golub Austein/Wife 14609 Brougham Way, Gaithersburg, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 2-6-2012 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Jamie Arthurs M01163 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -₽nysician/ Months Metastatic Anaplastic Thyroid Cancer disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) tending physician and or use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical P.O. Box 68760 res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy atter for 5 Other (specify) Month Day Year Pregnant at time of death signed by the aid be detached for 1 Yes 2 g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 : autopsy performed? Yes 2 X N After this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 K Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat∕ne and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035045 2-4-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Dr., #200, Olney Maryland 20832 Philip G. Henjum MD, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland				and M	lental Hy	giene	20	1.0	05	575
-		-	Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate of	Death		2. Date of De	Reg. No.	20	14	3. Time of	
Г	Physicia Medic		. Decedents Name (1 1131, Middle, Lasty	Almeda	. Al	t				Februa		201	Year 2	5:30	
. Hang	Examir		4a. Facility Name (if not institution, give str	eet and number)			4b. City, Town, o	or Location o	of Death		4c.	County of	Death		
	<i>}</i> ∞	М	Brighton Gardens o 5. Social Security Number 6. Sex		ia e (In yrs. las	at hirthday)	Columb. If Under 1 Year		24 Hrs	8. Date of Bir	th	Howa		lace (State o	r Coming
200	Funeral Director			M 2 💢 F		Yrs.	Months Days		Min.	(Month, Da	ıy, Year)		Count	ry)	rroreign
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	arylan a-f sh fied a	Director	MD Howard		Colu	Town or Loc	cation						'	0d. Inside Cit	
	the Mi or 28 e noti		10e. Street and Number		Coca	muxa	10f. Zip Code				10g. Cit	izen of Wh	at Coun		
	s 23a nust b	Funeral	7110 Minstral Way				210	45			Un	ited	Sta	tes	
	r item		The manual states	2. Was Decedent E Armed Forces?		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orig an, Mexican,	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Black,	America White, e		
036	s after al", o Exam	d by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 If Yes, Give Year or Dates.	No	1	☐ Yes 2 💢 No	Specify:				0	Whi		
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation		16a. Deced	ent's Usual Occu ind of work done	pation	of worki	na .	16b. Ki	nd of Busi			
121	within 72 giene. er than '	Juo	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	life. Do	NOT use retired)	OI WOIKII	<i>'</i> 9		Ours L	Lama		
	led wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last)			пот	emaker	18. Mothe	er's Name	(First, Middle,		Own_H Surname)	iome		
/lan	d be filed Mental Hy Irked oth	은	George Harvey						vry	Har		,			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type,	*			g Address (Street				. ,		te, Zip C	ode)	
	and 2 Health em 27 ther tr		Margaret A. Schust	er, daug	_		Brantly sition (Name of	Road,					the contract	01-1-	
nor	Page 1 ment of ant: If it ury or o		1 M Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cei	metery, crem	atory or other pla)ate		cation - C			
Baltimore,	permit. P Departmi Importar any injur		21. Sig fature of Fune Service Licensee	1/00			LL Cemet Name and Addre					tlano Funor			Tuc.
m	2 2 E 6	1	Jary M.	fin 1200	209	11	800 New	Hamps	hire	Ave.	Sili	ver S	prin	g. MD	20904
			23a. Part 1. Enter the distase, or complice shock, or heart failure. List only one of immediate Cause (Final	ations that caused cause on each line	the death.	Do not ente	r the mode of dyir	ng, such as o	cardiac o	r respiratory ar	rest,			Approximate Interval Bety Onset and D	veen
يقسنر	Ph_sician/ Medical	9	disease or condition resulting in death)	CORONA:			DISEASE						2	MONTH	Š
	Examiner			Due to (or as a	a conseque	ince on.									
	_ #0	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a	a conseque	nce of:									
	and	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	conseque	ance off:							_		
0	cate be executed physician and the burial transit	edical E	resulting in deathy East	Duc to (01 as a	a conseque	inde dij.									
3760	ficate g phys	Medi	d.												
P.O. Box 687	h certi tendin or use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of	2 Fetal	death 3		су			- 4	23d. Date			
Bo	e deat the at thed fo	ysici	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	ath 5	Other (specify)					Month	n	Day Y	'ear
Ö.	hat th ed by detac	y Ph	Part II. Other significant conditions contr	ributing to death bu	ut not resul	ting in the u	nderlying cause g	iven in Part I.		23e. Did t	obacco u	se contrib	ute to the	e cause of de	eath?
) S	uires l	ed b	DEBILITY							1 🗆	Yes 2	X No 3	☐ Prob	ably 4 🗌 l	Jnknown
Sor	aw req	plet	ANEMIA							24a. Was		24b. We	re autop	sy findings a	vailable ause of
Be	The la	Com	COLITIS							perfo	ormed? 2 X No	dea 1 [ath? Yes		
ta	sician: certific rector	Be	25. Was case referred to medical examiner? 1 Yes 2 X No	spital:			_ Oth	lace of Deatl	1			v Áss	ist	ed Liv	ing
Division of Vital Records,	y Physer this eral di	e: To	27. Manner of Death	1 Inpatie	ry 2	8b. Time of	28c. Inju	4 L Nui ryat	$\overline{}$	me 5 Resident			(Specify)		
on	anding sath. or: Afte he fun	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	, Year)	injury	M 1 L	k? Yes 2 🗆	No						
NISI VISI	or Atta	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ıry - At hom :. (Specify)	ie, farm, stre	et, factory, office		1	28f. Location (\$ City or Tov		Number o	or Rural I	Route Numb	er,
Ξ	spital ours a ours a leral C		29a. Certifier 1 X Certifying Physicia	an: To the best of r	mv knowled	dge, death o	ccurred at the tim	e date and i	place an	d due to the c	ause(s) ar	nd manner	as state	d	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transferment.	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	On the basis of ex	xamination a	and/or invest	gation, in my opini	on, death occ	curred at	the time, date a	and place,	and due to	the cau	se(s) and mar	nner stated.
	To the within	-	29b. Signature and title of certifier	1			29c. Licens					e signed (/			
	10		•	b		I.D.	D56	531			Febr	uary	8,	2012	
			30. Name and address of person who com					#301	Cali	ımbia,	MD	21045	ñ		
	Stat	e.	Harry Li. M.D. 86 31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re /	· I	JU1	con	unuluş	עהו	21040			
	Registra		FFR 0 9 2012	12 June .	. A.	MAN	A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Day Physician/ Feb 3 Joseph America 11:20 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick 3010 Honey Cove Ct. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 🙀 M 2 🗆 F 02/24/1920 Washington, DC 577-12-9363 91 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Marvland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3010 Honey Cove Ct. 20678 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1XX Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinest Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Claude America Elsie Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam Gholl / Daughter 2412 Acacia Road, Port Republic, Maryland 20676 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln 02/07/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. M01206 Kyle S. Simons 4405 Broomes Island Road, Port Republic, MD 2067d 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARDIOVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 50233 1 200 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) GLYNIS

Registrar

DHMH 17 Rev 7/2009

State

DRIVE

#310

32. Registrar's Signature

VOSPITAL

(Month, Day, Year) FR - 6 201 12-01042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # Brack of Maryland / Department of Health and Mental Hygiene Jose Gilberto Flores 2012 05577 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 4, 2012 Alvarado 0807 hrs Gilberto Flores Jose **dical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hyattsville 2012 Armherst Road Spate of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Davs Hours 6/05/1961 Ecount Salvador 50 Director 450-87-1772 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b, County Hyattsville 1 Yes 2 X No Prince George MD or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho items 23a or 28a-f shoust be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number El Salvador 20783 2012 Amherst Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
El Salvadoran White, etc. Armed Forces? 1 Never Married 2 Married 2 X No White Yes 1 X Yes 2 No specify: Specify 4 X Divorced If Yes, Give Year 3 Widowed the Medical Examine Ŕ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Baltimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last) 8 Mother's Name First Middle Maiden SyraRe vera Gilberto Alvarado 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2012 Amherst Road Hyattsville, Md. 20783 Henry Flores/Son 20c Location - City or Town, State Batres, Usulutan, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
General Cemet
of Concepcion 1 X Burial 2 Cremation 3 X Removal from State or other El Salvador 2/11/2012 Department of Donation 5 Other Specific 21. Signature of Funeral Service e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physici<u>an</u> 23a Part I Enter Between Onset and failure. List only one cause on each line /Medical Death aCardiac Arrhythmia Immediate Cause (Final disease ∈xaminer or condition resulting in death) Due to (or as a consequence of): Cardiomegaly Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and \blacksquare AMENDED #1 as noted,23a-b,pt.II,27,per me,g925 3-12-12 sm S X UNPENDED e attending physician for use as the burial Physician/Medi To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 2 Fetal death Month Dav Live birth 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown this certificate has been signed by the director, page 2 should be detached fi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. à 1 Yes 2 No 3 Probably 4 V Unknown Cocaine and alcohol use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 🗸 Yes 1 ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٥ this 1 V Yes No After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) (Specify) Homicide 29a, Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 5, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD Registrar's Signaure State 31. Date filed (Month, Day, Year)

Registrar

08

FFR

State Registrar

31. Date filed (Month, Day, Year)
FEB 0 6 2012

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

604 South Frederick Avenue, #413, Gaithersburg, MD 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Mary		•			Mental Hy	/giene	012	05579
_		-	Registrar 1. Decedent's Name (Firs	st Middle [ast			C	ertificat	e or De	eatn	2. Date of De	Reg. No.	<u>U 4</u>	3. Time of Death
	Physicia		Cleotilde Ru								Month	Day	201^{Year}_{2}	2:45 P M
	Medic Examin		4a. Facility Name (If not in					4b. City	, Town, or L	ocation of Death			ounty of Dear	
			Casey House						ville				ntgome	
	Funeral		5. Social Security Number			7. Age (In	yrs. last birthda	y) If Under Months		Hours Min.	8. Date of Bi			thplace (State or Foreign buntry)
	Director		525-56-1281 Usual Residence of Dec] M 2 ፟M F	80) Yrs				April 8	8, 193	31 New	Mexico
and	shov	to	10a. State 10b.	. County			c. City, Town or							10d, Inside City Limits
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)03 safe	ural", I Exal	ed	3 🗆 Widowed 4 🛚 🛭	Divorced	If Yes, Gi Year or D	ive		1 🔼 Yes	2 ∐ No	Specify: Sp	anisn	Si	pecify: Ca	ucasian
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Var dbe	Menta arked	1	Aûgustin Luc	cero						Frances	A. Bar	num		
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e, e	Health tem 2	3	20a. Method of Disposition		a, 501		20b. Place of Di			- Roda,	Date		ation - City or	
Baltimore,	ent of it: If ii y or o		1 ☐ Burial 2 💢 Cn 4 ☐ Donation 5 ☐	remation 3 🗆 I		n State	cemetery, o	rematory or	other place)	ory 2/9/			-	Maryland
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n i			> lun	i Kou	R			1040_1	Rockvi	ille Pik	ce, Rock	ville	, Mary	land 20852
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DIVISION OT VITAI HECOLDS, tal or Attending Physician: The law requires	r deat sctor: by the	rtific	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	28e. Plac	e of Injury -	At home, farm,			30 22110			Number or Ru	ural Route Number,
Ea o	rs afte al Dire		1 Homeda	dotominad	build	ding, etc. (S	pecify)				City or To	wn, State)		
Hospi	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 🔲 N	Certifying Physi Medical Examin	er: On the ba	asis of exami	ination and/or in	vestigation, ir	my opinion	, death occurred	at the time, date	and place, a	and due to the	cause(s) and manner stated.
o the	vithin of the comple	Σ	only one) 3 100	Certifying Nurse	Practition	er: Io the be	st of my knowle		curred at the lc. License r		place, and due to		signed (Mont	
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			30. Name and address of											
			Debrah Mi 31. Date filed (Month, Da							kville,	Maryla:	nd 208	355	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1, 2012 Gennett Adams 11:10a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Nursing & Rehab. Ctr. Prince Georges Ft. Washington Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🖼 F Days Feb. 26, Year 941 Hours Director 490-46-8352 MO Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles County White Plains 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 20695 10g. Citizen of What Country? Funeral 3821 Pearl Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Assistant should be filed with and Mental Hygien 7 is marked other th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucy Surrat Jacob Jefferson and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3821 Pearl Street, White Plains, MD 20695Paul Adams / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Waldorf, MD 2-20-12 4 Donation 5 Other (Specify) Heritage Memorial 22. Name and Address of Facility
Alexander, S. Pope, P.A.
5538 Mariboro Pike/ Forestville, Md. 21. Signature of Funeral Service Lig LUKE MOLO81 20747 and 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ sign. Metastatic Lung Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Liver Metastasas or Attending Physician; The law autopsy performed? 2 🗌 No 1 🗌 Yes 1 ☐ Yes 2 🔯 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 D Residence 6 D Other (Specify) 1 Tyes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DQA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Division of Vital 24 hours after death. Funeral Director: At Hospital completed To the I within 2

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Edgar V. Potter, M.D.

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Box 68760

o.

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Records,

State

DHMH 17 Rev 7/2009

Registrar

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practionaria the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

11701 Livingston Rd. S#207 Ft. Washington, Md.

D42955

29d. Date signed (Month, Day, Year)

20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Pecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2153 M Physician/ ZC/2 702th TRICI A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours **Director** 1 🗆 M 2 💢 F 296-38-1160 69 Yrs. Ohio July 6, 1942 Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland | Anne Arundel Annapolis 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 849 Rudder Way 21401 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mediator Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Clifford Watson Hester E. Bentley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Elana R. Byrd/ Agent 91 Tarragon Lane, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 2/7/2012 Edgewater, Maryland 21. Signatur Fun Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTH S Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 2 🗌 No this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition of: 0 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Date signed (Month, Day, Year) 062012 cause of death (Item 23a) (Type, Print) Name and address of pers EXENSE HWY NNA POLISM DLI401 State FEB 0 8 20 Registrar

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dical Exam	iner	Paul Stewart Burnet 4a. Facility Name (if not institution, give street		14	b. City, Town, or L	ocation of Do		5, 2012	y of Death	1809 hrs
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24		Birth (MM/DD/YY	YY) 9. Birthp	lace (State or
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		Registrar 1. Decedent's Name (First, Middle	, Last)			Crimoato	, 01 12	catri		2. Date of De		-	16	3. Time of Death
Physicia Medic		Karle R.	Barnes							Month Februa	ary D	01, 2	^{rear}	10:00 P M
Examin	er	4a. Facility Name (if not institution,	, give street and number)					Location of	f Death		4	c. County of		
Funeral		HeartHomes 5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthda	Lint y) If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir	th	Anne	g. Birthp	lace (State or Foreign
Director		218-03-3209 Usual Residence of Decedent	1 X M 2 □ F	93	Yrs		Days	Hours	IVIII I.	Oct. 3	19, rear)	918	Count lary	land
land show dat	tor	10a. State 10b. County			y, Town or								1	0d. Inside City Limits
e Mary 28a-f)irec		Arundel	1	inth:								\perp	1 Yes 2X No
vith the	Funeral Director	10e. Street and Number 804 Camp Mead	le Road			10f. Zip	1090)			10g. C	USA	at Coun	try?
leath v	Fune	11. Marital Status	12. Was Decedent E Armed Forces?		S 1				in? (Spe	cify Yes or No- Rican, etc.)		14. Race		
urs after o ural", or i Il Examin	by	1 Never Married 2 Marr 3 X Widowed 4 Divorced	ried 1 X Yes 2 🗆	No WW	II	1 Yes 2			rueito	rticari, etc.)		Black, Specify:	White, e	
72 hou n "nat Aedica	Completed	(Specify only highe	nt's Education st grade completed)		(Gi	cedent's Usua ve kind of wor . DO NOT use	k done di		of worki	ng	16b.	Kind of Bus	ness/Ind	dustry
within giene. er tha , the N		Elementary/Secondary (0-12)	College (1-4 or 5	5+)		ice Pre	,	ent			Αj	ax Al	loy	Foundry
d be filed fental Hy irked oth tic event	To Be	17. Father's Name (First, Middle, L George Barnes								t Hermi		n Surname)		
d 2 should alth and N 27 is me		19a. Informant's Name/Relationsh Donna Rupp /	1 1 21		19b. Ma 21	ailing Address 49 Odes	(Street a	nd Number Circle	or Rura	Route Numbe	er, City o Lage	or Town, Sta		162
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 ☐ Removal from State	20b. P	emetery, c	sposition (Namerematory or ot rematory or ot	her place	FEINC.	eb. 「	03, 2012		Location - C		
permit Depart Import any inj once.		21. Signature of Funeral Service L	icensee]	22. Name and Barrand 495. Rit	Address CO &	Sons, Hwy	P.	A. Seve	erna erna	Park Park	Fun MD	eral Home 21146
Physician/ Medical		23a. Part 1 Enter the disease, or shock, or head failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each line a. Due to (or as	DKY	n. Do not e					r respiratory ar	rrest,			Approximate Interval Between Onset and Death
Examiner	<u>r</u>	Sequentially list conditions,	b. ———		, , , , , , , , , , , , , , , , , , ,									
red	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):									
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ath certifi attending for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	death	3		У				23d. Date Mont		ery Day Year
requires that the der been signed by the s should be detached	by Ph	Part II. Other significant condition	ons contributing to death b	ut not res	ulting in th	ne underlying c	ause give	en in Part I.		23e. Did t	obacco	use contrib	ute to th	e cause of death?
quires en sign	ted b	LAyre	nxnm							1 🗆	Yes 2	2 🗆 No 3	☐ Prob	pably 4 Unknown
sician: The law red certificate has bee lirector, page 2 sho	Completed											pri de	or to cor ath?	osy findings available impletion of cause of
sian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?					26. Pla	ice of Death	n (Check	1 \(\superset \text{Yes}\)	2 /5			
Physic this corral dire	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati 28a. Date of inju		ER/Outpa 28b. Time	tient 3 DC	Othe Bc. Injury	4 ∐ Nur		me 5 Resid		GX_I Other	Specify)	15 living
Attending Ph er death. ector: After th by the funeral	icate	1 ► Natural 5 □ Pendin 2 □ Accident Investig	g (Month, Day		injur		work?			28d. Describe I	now inju	iry occurred		
al or Atters s after des I Directored in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e Place of Inju			street, factory,	office			28f. Location (S City or Tov			or Rural	Route Number,
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the t	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e Nurse Practitioner: To th	xamination	and/or inv	vestigation, in n	ny opinio	n, death occ	curred at	the time, date a	and plac	e, and due to	the cau	ise(s) and manner stated.
To the within To the comple		29b. Signature and title of certifier	- The			29c.	License	number				ate signed (
		20 Name and address		Vy nath (Itam	220\75-	o Drint\	20	<u>የጉ</u>	•		2	121	201	2
#5+1		30. Name and address of person v	who completed cause of d	TAZ		e, Print)	uv	~,	83.	286 A	S.	Sur	20	~
Stat	е	31. Date filed (Month, Day, Year)	2012 32. Registra	ar's Signat		0	,			, ,			0	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 01 Nevesa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Anne Medica Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Hours Min. 10/20/1976 553-87-9059 35 Director Usual Residence of Decedent 28a-f show at 10a. State 10h Counts 10c. City, Town or Location Director be notified Severna Park Marvland Anne Arundel 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 625 Thomas Way 21146 Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. þ "natural", or 1 Never Married 2 Narried 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. **7 is marked other than "**n Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Banking Financial Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Somkith Vongvilath Yong Vongvilath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Thomas Way, Severna Park, MD 21146 and 2 s Health Kevin Barrett - Husband 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State Prospect Hill Cemetery 2/2/2012 Front Royal, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens Moelin 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Po in the past 12 months? 1 Yes 2 No Month Pregnant at time of death ☐ Yes ☐ ☐ ☐ Unknown Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tephriti Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Physician: The 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes 2 No Other: ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending thin 24 hours after death. the Funeral Director: After propleted filled in by the fun 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number DO016768

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year 2017

Anu

Birthplace (State or Foreign Country)
 T

Laos

10d. Inside City Limits

USA

Approximate Interval Between Onset and Death

Dav

1 ☐ Yes 2 ☐ No

2017

Year

1 Yes 2 X No

0201 AM

Registrar DHMH 17 Rev 7/2009

State

110 S. Puca St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Pi				K. Ensure A Health and N	•		gibie.	
	1	For State Of Its S	nai yiai i		tificate of L		, ,	g. No. 2	112	05586
Physician Medic	1/	1. Decedent's Name (First, Middle Last)	BA	ALL			2. Date of Death	Day	2012	3. Time of Death 0 + 20 M
Examine	er	4a. Facility Name (if not institution, give street and number, Anne Arundel Medical Cent				r Location of Death			y of Death Arund	el
Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,)	'ear)	9. Birthpla Country	ice (State or Foreign
Director		217-44-2645 1 □ M 2 F Usual Residence of Decedent	66	Yrs.			9/24/19	945	Washi	ngton, DC
a-f sho	Director	10a. State 10b. County	10c. City	Town or Lo					100	d. Inside City Limits 1 ☐ Yes 2 👿 No
or 283		Maryland Anne Arundel 10e. Street and Number		Riva	10f. Zip Code		10	-	What Country	- 21
ms 236 must b	Funeral	2738 Hambleton Road 11 Marital Status 12. Was Deceden	A Francis II C	10.1	2114	O lispanic Origin? (Sp	onify You or No.	USA		Indian
, or ite	ह	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Deceden Armed Forces 1 □ Yes 2 ☐ If Yes, Give	?	1	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		ce - American ick, White, etc Whit	Э.
latural'	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education		16a. Deced	lent's Usual Occur	pation	1		Business/Indu	
than "r e Med	omo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 o	r 5+)	life. De	O NOT use retired)	during most of work	ing		et Bus	
Hygie other ent, th	a	12th 17. Father's Name (First, Middle, Last)		D00	kkeeper	18. Mother's Nam	ne (First, Middle, Ma			THESS
Mental Mental arked atic ev	욘	Wendell Giles Reno					e Tilley			
perfilt. rage I and 2 should be the while it follows site dealt will the way said bear and 2 should be the stand should be the stand bear than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Bruce B. Beall/ Husband				and Number or Run on Rd., R				de)
or othe	Ì	20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from Sta	te ce	emetery, cren	sition (Name of natory or other place	ce)			- City or Tow	
oartmer sortant / injury	ŀ	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Lal		Cemeter . Name and Addre	y 2/6/ ss of Facility Geo			onvill Tuneral	
	\perp	MULLILLE		2	973 Solo	mons Isla	ind Rd. E	dgewat	er, MD	21037
hysician/		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition		5 P	FAILU	RE	or respiratory arres	τ,		Approximate nterval Between Thetand Death
Medical Examiner	_	Sequentially list conditions b.	s a consequ	TOE	STRUC	TUE (POVELIN	NONIK	+	DAYS
nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequ	ence of):	s C	A				MONTHS
cian	a	resulting in death) Last Due to (or a	s a consequ	ence of):						
ding physe as th	/Med	IF FEMALE: 23b. Was decadent program 23c. If yes, outcom	ne of pregnar	nev						
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1	n 2 □ Fetal tat time of d	Ideath 3	Ectopic pregnand Other (specify)	су			ate of delivery	V Day Year
n signed by	ا ۾	Part II. Other significant conditions contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Part I.				cause of death?
e has bee age 2 sho	Completed						24a. Was an autopsy perform	ed?	Were autops prior to compleath?	y findings available pletion of cause of
ctor, p	BeC	25. Was case referred to medical examiner?				lace of Death (Chec	1 Yes 2 ck only one)	≥ NO	T res 2	
this ce	욘	Hospital:		ER/Outpatier	oth 3 DOA Oth 28c. Injur	4 LI Nursing H	ome 5 Resider			
eath. or: After the fune	Certificate:	1 Natural 5 □ Pending (Month, L) 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		injury	worl	Yes 2 No				
irs after d al Direct		4 ☐ Homicide determined 28e. Place of 1 building,	etc. (Specify)		eet, factory, office		28f. Location (Stre City or Town,	State)		
e Funer	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best 2 Medical Examiner; On the basis of Certifying Nurse Practitioner; To	f examination	and/or inves	tigation, in my opini	on, death occurred a	at the time, date and	place, and d	ue to the caus	e(s) and manner stated.
withir To th сопр		29b. Signature and title of certifier	-1	lm	29c. Licens		29		ed (Month, Da	
154		30 Name and address of person who completed cause of	f death (Item		Print) DET	CENSE +	tuy AN	NAD	ous n	0 21401
Stat Registra		31. Date filed (Month, Day Year) FEB 0 6 2012	strar's Signat	lire de	New York		- /	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ellen Ann Bennett February 10 2012 3:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing and Rehabilitation Cen Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth MD Country) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2**X** F 10/7/1936 75 **Director** 219-32-5107 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f XX Yes 2 No MD Berlin Worcester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 401 West St. USA 21811 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1X Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced al Hygiene.
d other than "nature event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Transcriptionist Baltimore City Hospital 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of r traumatic ever ၉ Page 1 and 2 should be George Joseph Dzieklinski Agnes Puchalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace Charles B. Bennett (husband) 401 West St. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛭 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation Sacred Heart of Mary Cem. 2/13/12 Baltimore, MD 5 Other (Specify) 21. Signature of 22. Name and Address of Facility The Furbage Funeral Home 108 William St. Berlin, MD 21811 helas 23a. Part 1. En er to dilease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail are. List only one cause or each line. Approximate Interval Between immediate Cause (Final Onset and Death Physician/ 17/1 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or ilinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \nearrow Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🕱 No completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ျ 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Name Fraction ared at the time, date and place, and de 29b. Signature and title of certify 29d. Date signed (Month, Day, Year)

Ellen A. vland 21215-0036

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Bennet timore,

Box 68760

P.0.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year

FEB

William H. Robins, MD 9715 Healthway Dr, Berlin, MD 21811

un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) February 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 05588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ February 20**1**2 Florence Willey Brohawn 11:42а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dorchester General Hospital Cambridge Dorchester 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Dec. 18,1929 1 🗆 M 2🛣 F Months Days Hours Min. Mary land Director 218-24-5182 82 Usual Residence of Decedent or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Medical Examiner must be notified at Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Glenburn Avenue 21613 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. "natural", If Yes Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Frank Willey Mary Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sha Department of Health ar Important; If item 27 is Terry Robbins daughter 5253 Ragged Point Rd., Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dorchester Mem. Park 2/7/12 Cambridge, MD nature of Funeral Service iscensee 22. Name and Address of Facility Thomas Funeral Home P.A. Cambridge, MD 21613 700 Locust St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Oncet and Death metastatic lung cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): was Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit Exami Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, emphesema, hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 X No 1 Yes 2 X No Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 X No ည 1 Yes 1x Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this: To the Hospital or Attending Pr within 24 hours after death.

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner; 19 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and margner as stated. (Check only one) 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name an

31. Date filed (Mo

of person who

Day,

Box 68760

P.O.

Division of Vital

eath)(Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Paul Randall Birch Februar 01045A M 2012 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Dorchester HOSPI Dorchister General Combridge If Under 1 Year | If Noder 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 ₩ M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Funeral Days Hours Mary Land 1943 219-42-8748 Director 68 Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany Injury or other traumatic event 1 XYes 2 □ No Director Secretary Maryland Dorchester 10e, Street and Number 10g. Citizen of What Country? USA 170 Main Street 21664 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ∐Yes 2 🛣 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music Producer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Cecilia Wanex Paul Thomas Birch မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna Birch/Wife P. O. Box 7, Secretary, Maryland 21664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Our Lady Of Good Counsel 2/13/2012 Secretary, Maryland 21 Pinnature of Puneral Service Lice see 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Recamen-Palenens **Physician** /Medical Due to (or as a consequence of): **Examiner** ulmonory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Seners and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 / NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 Mo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 47924

State Registrar 31. Date filed (Month

Baltimore, Maryfand 21215-0036

Division of Vital Records, P.O. Box 68760,

503

Registrar's Signature

ST CAMBRIDGE MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BARONE VINCENT JR FEB 2:11 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3724 Warwick Road East New Market Dorchester 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 105-26-6897 Usual Residence of Decedent **Director** 1 X M 2 - F 75 11/10/1936 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Dorchester East New Market 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3724 Warwick Road 21631 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1953-1973 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) <u>Chief Pettv Officer</u> Military other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vincent Barone Sr. Amelia Nepo of Health and It item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Barone/wife</u> <u> 3724 Warwick Rd. Fast New Market. MD 21631</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/17/2012 Cambridge, MD Midshore Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High St. Newcomb and Collins F.H.Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CONGESTIVE HEART FAILURE 5 YEARS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 5 YEARS CHRONIC RENAL Sequentially list conditions, Examiner Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D0070752 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROHAN 503 EYRN ST CAMBRIDGE MD

State Registrar

MOFFATT

MD

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State 0	f Marylanc		artment of He		1ental Hyg	iene	
	_	-	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatri	2. Date of Deat	eg. No.	3. Time of Death
	Physicia		Gloria Mae Bentor	1				Month		ear
	Medic Examin		4a. Facility Name (if not institution, give street and num	ber)		4b. City, Town, or L			4c. County of	Death
-			Coastal Hospice at 2			Salis			Wie	omico
	Funeral Director			7. Age (In yrs. las	**	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
			214-32-6147 Usual Residence of Decedent	84	Yrs.			Nov. 13	1927	Maryland
	and show	tor	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary 28a⊸ ootifie	Director	Maryland Somerset		Prin	cess Anne				1 ☐ Yes 2 No
	th the 3a or t be r	ral D	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
	ath wi	Funeral	30380 Maple Street, Ap	dent Ever in U.S.	13. \	21853 Vas Decedent of His	panic Origin? (Spe	cifv Yes or No-	U.S.	American Indian,
ဖွ	ter de , or its ımine	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	ces? 2 🔀 No	'	f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, ¹	White, etc.
8	urs af tural", al Exa		3. Widowed 4 □ Divorced If Yes, Given Year or Date of the Property of the State of				Specify:		Specify:	White
5	72 ho n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	lent's Usual Occupat kind of work done du O NOT use retired)	tion vring most of worki	ng	16b. Kind of Busin	ness/Industry
72	vithin jiene. rr thai		Elementary/Secondary (0-12) College (1-	4 or 5+)		nemaker			Own Hor	ne
b	filed valued Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)	
Хa	ld be Menta iarked atic e	욘	Walton Henry Tawes				Mabe1	Mae Dai	niels	
Maryland 21215-0036	shou hand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)		l	ng Address (Street an			-	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Bonnie Muir Daughter 20a. Method of Disposition	20b. Pla		+ Crisfiel sition (Name of			S Anne, I	
JO L			1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cer	metery, cren	natory or other place, .s Cemeter)	9/2012		, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.	13	21. Signatu Funeral Service Licensee	500		. Name and Address	<u> </u>			· · · · · · · · · · · · · · · · · · ·
m	e a T E e	.10	fam d. 4 f	M00295						ne, Md. 21853
			23a. Part 1. Enter the disease, or complications that cock, or heart failure. List only one cause on each distribution of the course (Final	aused the death.	1	1110 TRAC 14		r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician/ Medical	8 9	dis ase or condition	or as a conseque		40804	144			
	Examiner			27 40 4 00 100 440	3,100 0,7					
	n t	Examiner	cause. Enter Underlying	or as a conseque	ence of):					23
	ecuter and -trans	xan	Cause (Disease or injury that initiated events c Due to (or as a conseque	ence of:					
0	certificate be executed anding physician and use as the burial-transit	edical F		,	,					
3760	ficate g physas the	Medi								
89 ×	h certi tendin or use	ian/ľ	23b. Was decedent pregnant	come of pregnant Birth 2 Fetal		Ectopic pregnancy			23d. Date of	•
Box	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 horths? 1 □ Yes 2 □ No 9 □ Unknowh	nant at time of de lown	eath 5	Other (specify)			Month	Day Year
P.O.	law requires that the nas been signed by the e 2 should be detach	y Ph	Part II. Other significant conditions contributing to de	eath but not resul	lting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
	uires t n sign uld be	ed by						1 □ Ye	s 2 🗆 No 3	Probably 4 Unknown
Records,	as bee 2 sho	Completed						24a. Was an		re autopsy findings available or to completion of cause of
Re	The ate h	Com						perform	ned?") dea	
ta	ician: Sertific rector,	Be	25. Was case referred to medical examiner?			26. Plac	ce of Death (Check	only one)	- //2	11 00000
<u> </u>	ding Physician: h. After this certific funeral director,	5: To	1 Yes 2 No Hospital: 1 = 27. Manner of Death 28a. Date of the control of the cont	Inpatient 2 E	R/Outpatier 28b. Time of	t 3 DOA 28c. Injury	4 L Nursing Ho	me 5 Reside 28d. Describe hov	nce 6 Other (Specify) Hospich
o uc	nding ath. :: After	icate	Natural 5 Pending (Mont)	th, Day, Year)	injury	work?		Edd. Describe flor	w injury occurred	
Division of Vital	r Atte ter dez rector	Certificate:		of Injury - At hom	ne, farm, stre	eet, factory, office		28f. Location (Str City or Town,		r Rural Route Number,
á	oital o									
	To the Hospital or Attending Physiciam: which 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 17 Certifying Physician: To the be (Check 2 Medical Examiner: On the bas only one) Certifying Nurse Practitioner:	is of examination a	and/or invest	igation, in my opinion	, death occurred at	the time, date and	d place, and due to	the cause(s) and manner stated.
	To the within To the Comp	_	29b. Signature and title of certifier			29c. License			d. Date signed (N	
	14					1000	58410		02/08	5/12
	1,0		30. Name and address of person who completed caus	e of death (Item 2	23a) Type, F	Print) 0 1733	SACI	Saux	W us	2/802
- 47	Stat	e	31. Date filed (Month, Day, Year) 32. Re	edistrar's Signatu	ire	1	2/11	- 10	<i>y</i>	
	Registra		FEB – 9 2012	Ener	B. 14	early				

M. Benton

1 Natural
2 Accident
3 Suicide
4 Homicide

29a. Certifier (Check

Director

Funeral

Completed by

Be

2

Physician/

Medical

Examiner

Funeral

Director

	Plea					Ink. Ensur of Health an		•	_	ble.		
For State Registrar		State	or ivial yial			of Death	IG IVIE	Reg.	00	10	na	592
1. Decedent's Nam	e (First, Middle	, Last)						2. Date of Death	<u> </u>	2 6-10	3. Time	of Death
Ethel	Victor	ia Bran	dwein				F	'ebruary	3, 201	Ž ^{rear}	7:05	5 рм
4a. Facility Name (if	not institution,	give street and nu	mber)		4b. City, To	wn, or Location of D	Death		4c. County o	f Death		
Renaissa	nce Ga	rdens at	Riderwood	1 Villag	e S1.	lver Spri	ng		P.G.			
5. Social Security N 081-24-9		6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Months D			B. Date of Birth (Month, Day, Yea ug. 22, I	923	9. Birth Cour	nplace (State ntry) NY	or Foreign
Usual Residence of	Decedent 10b. County		10- 0	. T	-4:					-	40.1.	07. 117
10a. State	TOD. County		10c. CI	ty, Town or Loc	ation						10d. Inside	
MD 10e. Street and Nur		tgomery	S1	lver Sp	pring 10f. Zip Co	ode		10g.	Citizen of WI	hat Cou		és 2 No
3126 G	racefi	eld Road,	BG-310)	2090	4		US	A			
11. Marital Status 1 Never Marr 3 Widowed	ried 2 🔀 Marr	12. Was Dec Armed F	cedent Ever in U. forces? s 2 🛣 No ive	.S. 13. W	f Yes, specify	t of Hispanic Origin' Cuban, Mexican, P No Specify:	? (Speci uerto Ri	fy Yes or No- can, etc.)	Black	- Ameri , White, Vhit		
		nt's Education		16a. Deced	lent's Usual O	Occupation		165	. Kind of Bus	iness Ir	ndustrv	
(Specification)		st grade completed	d) (1-4 or 5+)	(Give k	kind of work d O NOT use rei	lone during most of	f working	1 100				
Liementary/360	ay (0-12)	College (5+	Pol:	<u>itica</u> l	Scientis	st	Go	vernme	ent	Contr	actors
17. Father's Name (First, Middle, L	ast)				18. Mother's	Name (First, Middle, Maide	en Sumame)			
August	Weiss					Alma K	ris	toferson				
19a. Informant's Na		1 1 22 2 2				treet and Number o						
Seymour	Brand	wein/Hush	and	3126 (Gracef	ield Road	1, B	G-310, Si	lver S	Spri	lng, M	D 20904
20a. Method of Disp 1 Burial 2 4 Donation	X Cremation	3 ☐ Removal from pecify)	m State	Place of Dispos cemetery, crem ropolit	natory or othe	r place)	Feb. 20	6.	Location - C	•		
21. Signature of Fu	neral Service L	icensee	D.	Fr. 50	Name and A ancis O Univ	ddress of Facility J. Collin Versity B.	ns F lvd.	uneral Ho	ome In ver Sp	c. rin	g, MD	20901
23a. Part 1. Enter t	the disease, or	complications that	caused the dea			f dying, such as car					Approxim	ate
Immediate Cause ((Final	nly one cause on e	each line. -Stage I	Dementi	а						Onset and	d Death
disease or condition resulting in death)	on	a	o (or as a conseq							+	3 yrs	•
		ASC									4 yrs	3
Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	b. Due to	(or as a conseq	uence of):						\dashv		
that initiated events resulting in death)	s	c. — Due to	o (or as a conseq	uence of:						-		
			,									
		d								-		
IF FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2 D 9 Unknown	months?	1 🔲 Live	utcome of pregna e Birth 2 Fet gnant at time of known	al death 3	Ectopic preci				23d. Date Mont		very Day	Year
Part II. Other signif	ficant conditio	ns contributing to	death but not re	sulting in the ur	nderlying cau	se given in Part I.	•	23e. Did tobacc	o use contrib	ute to t	the cause of	death?
Diabetes	s Mell1	tus						1 ☐ Yes	2 XNo 3	≀ □ Pro	bably 4	Linknown
Diabete	s merri	, cus										
								24a. Was an autopsy performed	pri ? de	ior to co ath?	opsy findings ompletion of 2 \Bullet	available cause of
25. Was case referre	ed to medical					26. Place of Death (Check o	1 ☐ Yes 2 🔣	NO 1	res	Z LI NO	
examiner?	No No	Hospital:	Inpatient 2	EB/Outpation		Other:		e 5 🗆 Residence	6 7 046-	(Spanis		
27. Manner of Death	h	28a. Date	e of injury	28b. Time of	28c.	Injury at		d. Describe how in			у/	
1 ♣ Natural 2 ☐ Accident	5 Pendin	9	nth, Day, Year)	injury	м	work? 1 ☐ Yes 2 ☐ No			,			
3 Suicide 4 Homicide	6 Could r	not be 28e. Plac	e of Injury - At h	ome, farm, stre	et, factory, of	ffice	28	f. Location (Street	and Number	or Rura	d Route Nun	nber,
4 🗀 Homicide	geterm!	neu buile	ting etc (Specif	1/1			1-0	City or Town Str	tol			,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

112633

29d. Date signed (Month, Day, Year)

3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit been signed by the attending physician and should be detached for use as the burial transit

Be Completed by Physician/Medical

Certificate: To

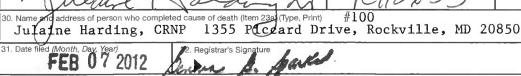
Medical

10

State Registrar

31. Date filed (Month, Day, FER 0 Year)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registra	D#24a :b oer	State of M MD, 2/7/12;BM	,	_	irtment of F tificate of L		d Mental Hy	gien: Reg. N	0010	05503
	Physicia	n/	1. Decedent's Name	(First, Middle, Las	st)					2. Date of De Month	ath	av Year	3. Time of Death
	Medic Examin	al	Doris I 4a. Facility Name (if r					4b. City, Town, or	Location of De	Januar		9, 2012 c. County of Death	8:10pm M
	LAGIIIII		3205 Bunk					Mount Ra				rince Geo	rge's
F	Funeral Director		5. Social Security Nu 579-44-66 Usual Residence of I	61	ex M 2 X F	e (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year)	9. Birthp Count 31 North	clace (State or Foreign Carolina
	yland •f show ed at	ctor	10a. State	10b. County		10c. City,	, Town or Loc	ation		-		1	0d. Inside City Limits 1 Yes 2 No
	ne Mar or 28a notifi	Dire	MD 10e, Street and Num	Prince G	eorge's	Mou	nt Rai	nier 10f. Zip Code			10a C	Citizen of What Coun	
	with the s 23a c ust be	Funeral Director	3205 Bunk	er Hill	Road			20712				ted State	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates.	Ever in U.S. No	If	Vas Decedent of H Yes, specify Cuba	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - America Black, White, e Specify: Blac	etc.
2-0	2 hour "natu	plete	(Spec	15. Decedent's E	ducation			ent's Usual Occup		rorkina		Kind of Business Inc	lustry
21215-0036	ithin 7; ene. • than the Me	Completed	Elementary/Seco		College (1-4 or 5	ō+)		NOT use retired)	<i>g</i>			National graphic	
d 2	iled will Hygid Other	Be	17. Father's Name (F	irst, Middle, Last)			OTELK		18. Mother's N	lame (First, Middle,			
ylar	Ild be i Menta arked	2	Unknown						Unknow	n.			
, Maryland	nd 2 shou ealth and m 27 is m			e D. Bro	ype, Print) adnax/Daug	ghter						ner, MD 2	
Baltimore,	Page 1 all ment of H tant: If itel iury or oth		20a. Method of Dispo 1 XBurial 2 Donation		Removal from State fy)	ce		sition (Name of patory or other place oln	ne) 1/:	Date 28/2012		ntwood, M	
Bai	Depart Depart Impor any in		21. Signature of Fun	eral Service Licens	c Grive							al Servicington, D.	
П			shock, or heart	failure. List only o	plications that caused ne cause on each line		. Do not ente	r the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
راسم	Ph_sician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Aspira			onia					Onset and Death
	Examiner				Due to (or as	a conseque	ence ory:						
	-	niner	Sequentially list con if any, leading to impose cause. Enter Underl	mediate ying	Due to (or as	a conseque	ence of):						
	secuted and littrans	Examiner	that initiated events resulting in death) L		c. Due to (or as	a conseque	ence of):					-	
9	icate be executed physician and sthe burial transit	edical		L	l d								
98760	rtificate ing phy e as th		IF FEMALE:		00- 16								
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 X 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	y			23d. Date of delive Month	ery Day Year
ds, P.C	quires that I	ed by P			ontributing to death b				ven in Part I.			use contribute to th	e cause of death?
Recor	The law rec ate has ber page 2 sho	Completed by								24a. Was auto perfo 1 \(\sum \text{Yes} \)	osy rm ed ?	prior to cor death?	osy findings available mpletion of cause of
ital	ician: certific ector,	Be	25. Was case referred examiner? 1 Yes 2 X		Hospital:			Oth	ace of Death (Ca				
of <	g Physer this leral di	e: To	27. Manner of Death		28a. Date of inju	iry :	ER/Outpatien 28b. Time of	28c. Injury	4	Home 5 Resident 28d. Describe		6 Other (Specify) ury occurred	
on	eath. or: Aft the fur	ficat	1 ♣ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not b		y, 16ai)	injury	M 1 🗆	Yes 2 No				
Sivis	al or Att s after d I Direct d in by	Certificate:	4 Homicide	determined	28e. Place of Injubulding, etc		ne, farm, stre	et, factory, office		28f. Location (S City or Tov		nd Number or Rural e)	Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in my opinic	on, death occurre	ed at the time, date a	and place	ce, and due to the cau	se(s) and manner stated.
	To the within To the Coorning		29b. Signature and ti		20 Siph			29c. License				rate signed (Month, E	Day, Year)
			30. Name and address	ss of person who coingh, M.	completed cause of d	eath (Item : Galla	23a) (Type, P nt Fox	Lane Bo	wie, MD	20715			
	Stat Registra		31. Date filed (Month	Day, Year)	2 Registra	ar's Signa	are for	رايا					

DHMH 17 Rev 7/2009

			Please	Type or Pr					-		_	
			For State Registrar	State of M	laryland / De		nent of F cate of D		d Mental Hy	giene Reg. No	2012	05594
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,					2. Date of De	eath		3. Time of Death
with .	Medic Examin	al	LUCTLLE SEWELL B 4a. Facility Name (if not institution, give			4b.	City, Town, or	Location of De	02/02/		. County of Deat	0200 M
THE STATE OF THE S	LXaiiiii	CI	Shady Grove Adve		pital		ockvill				iontgome	
	Funeral Director		5. Social Security Number 6. S 213-46-5801 1	ex	ge (In yrs. last birthd	Mor	Inder 1 Year oths Days	If Under 24 H Hours M	Hrs. 8. Date of Bir lin. (Month, Da			thplace (State or Foreign untry)
			Usual Residence of Decedent 10a. State 10b. County	- M Z A	65 Yrs				07/14/	/1946	5 ME	
	arylan ta-f sh ified a	ecto	MD Montgam	erv	Germant		l					10d. Inside City Limits 1 Yes 2 □ No
	a or 28	I Dir	10e. Street and Number				f. Zip Code			10g. Cit	tizen of What Co	ountry?
	th with ms 23 must	Funeral Director	19622 Scenery Dr	ive	Even in 11 C		20876	on an in Origin?	(Specific Ven ex No.	USA		
ဖွ	ter des or ite		11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X		If Yes,	specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		14. Race - Ame Black, White	e, etc.
93	ours af atural" cal Exa	eted	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	160 D		es 2 XNo			$\overline{}$	Specify: Bla	
215	in 72 h e. nan "na Medic	Completed by	(Specify only highest gra Elementary/Secondary (0-12)		(G	live kind c	Usual Occupa of work done d Tuse retired)	uring most of v	vorking	16b. K	ind of Business	Industry
121	d within the	Be Co	12th 17. Father's Name (First, Middle, Last)	9-(Hou	seke	eping_	40.14.11.1.1		Han		-
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.	To E	Edward Frazier						Name (First, Middle, a Sewell	, Maiden	Surname)	
Man	2 shoul th and I to ma trauma		19a. Informant's Name/Relationship (T) William Leon Sew		1.1	-			Rural Route Numbe Silver Sp			
ē,	1 and of Healt item 2		20a. Method of Disposition		20b. Place of D	isposition	(Name of		Date Date	1	ocation - City or	
imo	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Ash Nem	oria.		02	/13/2012			
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licen	Laure	lint				Snowden F n St, Roc			
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only o	olications that cause ne cause on each lin	d the death. Do not							Approximate Interval Between
مالاشر	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. card	iorespina consequence of):	roti	vy.	failul	ve			Onset and Death
mel.	Examiner			Due to (or as	a consequence of):	Phe	rmon	ia				
	· Q	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of): a tion a consequence of): bro vasc	· · · la	c a c	eiden	+			
	an and irial-tree	IWI I	that initiated events resulting in death) Last	Due to (or as	a consequence of):				,			
09	eath certificate be exe attending physician for use as the burial	Physician/Medical		d. myo	cardial	int	arctio	<u> </u>				
687	sertifica nding p use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	livery
Box 68760	death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death at time of death		opic pregnanc er (specify)	ý	***		Month	Day Year
P.O.	es that the dea signed by the a l be detached f		Part II. Other significant conditions of	ontributing to death I	but not resulting in t	he underl	ying cause giv	en in Part I.	23e. Did t	tobacco u	use contribute to	the cause of death?
ds, I	requires t been sign should be	ed by	chronic kidn	ey disci	250				_ 1 🗆	Yes 2	☑No 3□P	robably 4 🗌 Unknown
COL	law rec has bee ge 2 sho	Completed	diabetes	-					24a. Was	psy	prior to	topsy findings available completion of cause of
II Re	sician: The certificate I irector, pag	e Cor	hypertengior 25. Was care referred to medical	1			oe Die	use of Death (C	1 Yes	ormed? 2 🔀 No	death?	2 □ No
Vita	nysicia lis cert direct	To Be	examiner? 1 🗆 Yes 2 🗡 No	Hospital:	ient 2 🗆 ER/Outpa	atient 3	Othe	r·	g Home 5 Resi	dence 6	☐ Other (Spec	ify)
Division of Vital Records,	To the Hospital or Attending Phystcian: The law requires that the death certificate bewithin E4 hours after death certificate bewithin E4 hours after death. To the Luneral Director, After this certificate has been signed by the attending physicia gompletely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ury 28b. Tim ny, Year) inju		28c. Injury work 1 🗆	at ? Yes 2 \(\text{No}	28d. Describe I	how injur	y occurred	
Divisi	ital or Att irs after de al Directo		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm c. <i>(Specify)</i>	, street, fa	ctory, office		28f. Location (City or Tov			ral Route Number,
	he Hospital in 24 hours he Funeral ipletely filled	Medical	29a. Certifier 1 Certifying Physic (Check only one) 3 Certifying Nurs	ner: On the basis of e	examination and/or in	rvestigatio	n, in my opinio	n, death occurr	ed at the time, date a	and place	, and due to the	cause(s) and manner stated.
	with vith 10 to t		29b. Signature and title of certifier Blugger				29c. License	number 6450	2		te signed (Month	n, Day, Year)
					V.V.		000	- () -	-	rev	VY Y IN	-11-1

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Carpenter, MD 9901 Medical Centur Drug Fockville, Mony land 20550

31. Date filed (Month, Day, Year)

FEB 08 2012

April 1000

FEB 08 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death bay, Physician/ February Louise 2012 Virginia Bauknecht 1:48 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours **Dírector** 276-20-0212 1 □ M 2 🕱 F 87 Feb. 26, 1924 Ohio Usual Residence of Decedent 28a-f show with the Maryland ms 23a or 28a-f shormust be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Adclare Road 20850 USA death 1 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1X Never Married 2 ☐ Married 2 X No ☐ Yes Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify: White 'natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Journalist traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည John E. Bauknecht Merle L. Springer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other trauonce. John Bauknecht/Brother 112 Gelnaw Lane, Montvale, NJ 07645 3altimore, 20a. Method of Disposition
1 □ Burial 2 H Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Feb. Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA Funeral Service Lice Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ō in the past 12 months? Day Year Pregnant at time of death igned by the a 2X No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? death? certificate ! 1 ☐ Yes 2 ☐ No 2 XN Yes To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 2X No Other: 1 Yes 4 Mursing Home 5 Residence 6 Other (Specify) within 24 hours after deau..

To the Funeral Director: After this (မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) en lay MD D64624 February 7, 2012

State

9701 Veirs Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Sandeep Sharma, MD

08 20

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend#3 per fh 02/17/12 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (olden Brothers 12:300 January 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9309 Washington Blvd Lanham George's If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplac (State or Foreign **Funeral** Months Days Hours Min 226-22-2084 1 X M 2 □ F **Director** 88 June 6, 1926 VA Usual Residence of Dece 28a-f show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Prince George's Lanham be filed within (2 11-0...).

ental Hygiene.

riked other than "natural", or items 23a or 28.

rite event, the Medical Examiner must be no' 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9309 Washington Blvd 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: **Black** Specify: Completed 3 Widowed 4X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 8th Master Electrician and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Emmette D. Brothers Unknown . Page 1 and 2 should be thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Hurt/Daughter 11913 Berrybrook Terrace, Upper Marlboro, MD20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 \Box Cremation 3 \Box Removal from State 02/24/1Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 5538 Marlboro Pike, Forestville, MD 20747 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ LUMB Cuncer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown P.O. signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No s after death I Director: A d in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined filled in I City or Town, State) within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

#\$74 UPLIMENT D 29d. Date signed (Month, Day, Year) Baltomore MOZMOG 1/29/12

State Registrar N JZe3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith

NS Rajapaise Mb 28 35

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		tificate of	Death			Reg. No.	
Physic cal Exam		Michael Edward	Bowen			-	2. Date of De Month February	eath	3. Time of Death 1210 hrs
A		4a. Facility Name (if not institution, a 3337 Memphis Lane	give street and number)		4b. City, Town, or Bowie	Location of D		4c. County	of Death George's
Funeral			Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Yea	ar If Under 2	4Hrs. 8. Date of B		Y) 9. Birthplace (State or
Director			K M 2 F 44	Yrs	Months Day		2.22	0/1967	Foreign Country)Illinois
any.		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
		MD PG	Bowi	Le					1 X Yes 2 No
Maryland 28a-f show d at once.	9C	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
ith the l 23a or notifie	喜	12325 Manship La	ne		20715	5		US	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of His		(Specify Yes or Nerto Rican, etc.)		e - American Indian, Black, te, etc.
after der ul", or i	by Fu		1 Yes 2 No ed If Yes, Give Year or Dates:	1	Yes 2X No		, , ,		Black
2 hours "natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)		16a. Decedent during mo	's Usual Occupat ost of working life.	tion (Give kind . DO NOT use	of work done retired)	16b. Kind of Bu	usiness/Industry
036 tithin 7; ene. er then	Completed	Listing (0-12)	8	Benef	its Spec	ialist		Priva	te
15-0 filed w Hygid d other		17. Father's Name (First, Middle, Las	•				ame (First, Middle,		a)
212. lid be: Mental marke	To Be	Ned Edward Bower 19a. Informant's Name/Relationship		10h Mailing	Addrong (Otro-		Lee Evans		vn, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of the and Mental Hygiene. Important of the Aris is marked other than "natural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ţ	Ruby Bowen/ Moth	her	12325	Manship	Lane,	Bowie, N	MD 20715	
Baltimore, permit. Pages I an Department of Hea Important: If ite Injury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State cr	ematory or oth		,	Date 2/10/2012		- City or Town, State el, Md
it. Pag rtment rtant:		4 Donation 5 Other Special 21. Signature of Funeral Service Lice			ational	ľ			
Dem Depa Impo		Variable	4 MOLOSS	ope Funer		MD 20747			
ৃhysician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on e	not cations that caused the death. I	rest, shock, or he	art Approximate Interval				
Examiner		Immediate Cause (Final disease or condition resulting in death)	Pontine Hemorrhage due	e to Hype	rtensive A	therosc1	erotic Card	iovascula	Disease Death
			. Hypertensive Atheresele		vascular Dis	ease			
_	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):						
uted nd ransit		events resulting in death) Last	Due to (or as a consequence of): d.				<u></u>		
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8760, ifficate be ag physici is the buri-	I/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy		Ectopic pre	ananov.	23d. Date of	
Box 687 he death certific the attending ped for use as the	Physiciar	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of death	h - H	er (Specify)		grianicy	Month	Day Year
D. B. trithe de by the	Phy	Part II. Other significant conditions	9 Unknown	ulting in the un	derlying course gi	yon in Bort I	230 Did to	phonon una contri	ibute to the cause of death?
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Division pital or Attendir ours after death.	rtific	3 Suicide 6 Could not	be 28e. Place of Injury - At hom	e, farm, street,	factory, office bu	ilding, etc.	28f. Location (S or Town, S		er or Rural Route Number, City
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:		4 Homicide 29a. Certifier 1 Certifying Physic (Check only one) Medical Examine	clan: To the best of my knowledge,	death occurre	d at the time, date	e and place, a	nd due to the caus	e(s) and manner	as stated.
To t To t	9	one) 2 Medical Examine 29b. Signature and title of certifier	er: On the basis of examination and/ and manner stated.	or investigatio	29c. License		at the time, date		ue to the cause(s) ed (Month, Day, Year)
Old I		Ormette Freikhall.	M()		O.C.M			February 3,	
ya	+	30. Name and address of person who		,					
		Pamela E. Southall, MD	Assistant Medical Exami		V. Baltimore	Street, Ba	ltimore, MD 21	1223	
Sta Regist	rar	FEB (Nº 9 2012")	32. Regist ir's Sign ture	K					

12-01410 Deanna Renee I	3roo		or Print in Bla e of Maryland /					egible.		2 0559			
		1- For State Registrar		Certific	ate of Death			Reg. No.	2012				
Physicia Medical Exami		Decedent's Name (First, Middle,L	Brooke				2. Date of Do Month Februar		Year	3. Time of Death 0654 hrs			
)		Deanna Renee 4a. Facility Name (if not institution, g			4b. City, Towr	4b. City, Town, or Location of Death			County of Death				
		1432 Knight Avenue		Dunkirk				Calvert					
Funeral Director		577-88-7618	Sex 7. Age	(In yrs. last birt 40			Ain	2/197	Foreig	hplace (State or n I ^{ntry)} Mary1and			
¥0¥	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
ie i	ž	MD	Calvert Dunkirk							1 Yes 2 No			
Maryla 28a-f d at o	Director	10e. Street and Number 10f. Zip Code							en of What Coun	try?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		1432 Knight Av				20754			USA				
	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent I Armed Forces?		13. Was Decedent o	t Hispanic Origin? (uban, Mexican, Pue		4. Race - Americ White, etc.	ean Indian, Black,				
	by Fu	3 Widowed 4 X Divorce	1 Yes 2 and If Yes, Give Year or Dates:	X No	1 Yes 2 🗓	No specify:		s	Specify: Whi	te			
	ed b	15. Decedent's Education (Specify	only highest grade com		Decedent's Usual Occ during most of working			1	16b. Kind of Business/Industry				
36 nin 72 s. than "-	plet	Elementary/Secondary (0-12)	College (1-4 or 5	′	chool Bus	Driver				ge's Count; lucation			
Baltimore, MD 21215-0036 eremi: Pages I and 2 should be filed within 7 Department of Health and Mental Hygierten. Important: If item 27 is marked other than nigury or other transmatic evect, the Medica	Completed	17. Father's Name (First, Middle, La	st)	1 2	CHOOL Dus		me (First, Middle			lucation			
	Be	Unknown				Janice			loyd_				
	2	19a. Informant's Name/Relationship		1	b. Mailing Address (S				or Town, State, 20754	Zip Code)			
and 2 lealth item 2 traum		Janice M. Lloyd 20a. Method of Disposition		20b. Place of	432 Knight of Disposition (Name o	f cemetery,	Dulikitk	20c. Lo	ocation - City or	Town, State			
MOF Pages 1 ent of 1		1 X Burial 2 Cremation 3		10	ory or other place) armony Ceme	etery 02	-21-201:	2 Ow:	ings. MI)			
altir mit. P partme iporta ury or	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A.											
	1	23a. Part I. Enter the disease, or or	m	M00715		. Harmony			,	20736			
Physician /Medical		failure. List only one cause on	each line.		•	-		irrest, snoc	k, or neart	Approximate Interval Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Probable S Due to (or as a conse		ue to Acut	e Pyelon	phritis						
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687 Sertific Iding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy						N	Month Day Year				
BOX death death d for u	ysic	1 Yes 2 No 9 V Unknow		time of death	Other (Specify)	***							
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Rec The l ficate l	히						1 ✔ Yes	2 No	1 📝 Yes	3 2 No			
/ital siciao: is certi lirector	æ	25. Was case referred to medical examiner?	Hospital: 1 Inpatier	nt 2 ER/O	26.P utpatient 3 DOA	Other Nu		Residen	ce 6 🗸 Other:	Scene			
Of V	<u>ان</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 28b.		Injury at Work?	28d. Describ			<u> </u>			
ion teath. tor: A	atio	1 X Natural 5 Pending 1 Yes 2 No											
Division of Vital Records, P.O. Box 68760, ral or Atteoding Physiciae: The law requires that the death certificate b its after death. **I Director: After this certificate has been signed by the attending physicate in by the funeral director, page 2 should be detached for use as the but	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, or Town, State)											
Cospital hours		29a. Certifier 4 Continue To the heat of my knowledge death conversed at the time date and place and disc to the course(s) and mapper as stated											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be execute within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical	(Check only	g Physician: 1 o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due the and manner stated.										
T William S	Ā	29b. Signature and title of certifier 29d. Date signed						ate signed (Mon	th, Day, Year)				
		30 Name/and address of person wh	of completed cause of de	eath (Item 23a)	0	.C.M.E.		Febru	uary 18, 201	2			
		30. Name/and address of person who/completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month Cay Year)

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:50 P M February 2012 Theodore Henry Miller Crampton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House **Rockville** Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 111-16-8799 1 **X** M 2 □ F 85 April 4, 1926 Patchrogue, NY Usual Residence of Dec show 10c. City, Town or Location 10a. State 10b. County Director ems 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 🗶 No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 6 Lakeside Overlook 20850 United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces' Black, White, etc. o Completed by 1 Never Married 2 X Married X Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Give Specify: Caucasian "natural", 3 Widowed 4 Divorced Year or Dates. 1945-1987 traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) If Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Officer US Army Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I ၉ Theodore Henry Miller Crampton Dora Clara Frieman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Janet W. Crampton, Spouse 6 Lakeside Overlook, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 2/9/2012 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute M01102 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ C. diff colitis Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events **Bacterial Endocarditis** Due to (or as a consequence of): resulting in death) Last burialnding physiciar Physician/Medical certificate be 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months? Month Year Yes 2 No 9 Unknown detached 9 Unknown P.O. by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Dilated Cardiomyopathy Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Chronic Obstructive Pulmonary Disease autopsy performed? Yes 2 X No has Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate F. Aortic Stenosis 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA npletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar Bindu Joseph,
31. Date filed (Month, Day, Year)

FFR 09 2012

DHMH 17 Rev 06-2011

1160 Varnum Street NE #21, Washington, DC

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D060634

February 8, 2012

20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#24aperMD, 2/14/12; BMW, MoCertificate of Death 2. Date of Death 3. Time of Death 2 Day Month Physician/ 2012 P M 8:15 Mathilda Cohen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hebrew Home Of Greater Washington Rockville Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Days 1 - M 2 X F Months Hours Min. **Director** 579-20-4405 86 Usual Residence of Decedent 10a, State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 ☐ No MDGaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 34 Owens Glen Court 20878 United States iral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 2 X No 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced White Year or Dates. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Max Blum Anna Skulnik permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Owens Glen Court, Gaithersburg Maryland 20878 Diane H. Parker - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns. 2-5-12 Falls Church, Virginia Signature of Funeral Service Licensee Edward Sage1 22. Name and Address of Facility Danzansky-Goldberg M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death Year 1 Yes 2 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si formpleted filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo64871 2-3-2012

Registrar DHMH 17 Rev 7/2009

State

Mira

31. Date filed (Month, Day, Year)

P.O.

Montrose Rd

6121

Rockville

20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli

Chi, Kiw 1/26/12/2 2225

			1 - For State AMEND	1perMD2/21	State of M l/12;BMW,McQ	<u> </u>	-	artment <i>tificate</i>			and M	lental Hy	giene Reg. N	00	12	05601	
	Physicia		Registra MFND#20kperFH.2/21/12; HW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Kiv A. Chi Month 1														
	Medio Examir		4a. Facility Name (if not institution, give street and number) Shady Grove Hospital						4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery			
	Funeral Director		5. Social Security Nu 214-23-1 Usual Residence o	.509 1 f Decedent	□м₂XF	87	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Date of Bir (Month) Bir (Month, Date of Bir (Month)	ay, Year)		Viet	nam	
Baltimore, Maryland 21215-0036	he Maryland or 28a-f sho onotified at	by Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of V							Ditizen of W		1 ☐ Yes 2 🖾 No					
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		15617 Jones Lane 11. Marital Status 1 □ Never Married 2 □ Married 11. Was Decedent Ever In Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give				20878						Black, White, etc.				
	/ithin 72 hours a iene. r than "natural the Medical Ex	Completed by	3 🕅 Widowed 4 🗆 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker						Specify: Asian 16b. Kind of Business/Industry Own Home				
	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) Lam Ho 18. Mother's Name (First, Middle, Maider Sy Hong														
	e 1 and 2 sho of Health an If item 27 is I		19a. Informant's Name/Relationship (Type, Print) Peter H. CHi - SON 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State			20b. Pl	1	Jone:	s Lan		rens		mber, City or Town, State, Zi Maryland 20 20c. Location - City or			78	
	permit. Page Department Important: any injury o			Other (Speci	fy)	(4) Nati	lonal 22	. Name and	Address	of Facility		ional	Fune	eral l	Home	h, Virginia nia 22042	
71 M	Physician/ / Medical Examiner		23a. Part 1. Enter the shock, or heard immediate Cause (findisease or condition resulting in death) Sequentially list control of the shock of the s	r ne disease, or com t failure. List only c Final n	plications that cause one cause on each lin	d the death	Do not ente	er the mode								Approximate Interval Between Onset and Death Week	
rds, P.O. Box 68760	cate be executed physician and the burial-transit	Physician/Medical Examiner	it any, leading to fin cause. Enter Underl Cause (Disease or in that initiated events resulting in death) L		equence of):												
	the death certifica y the attending pl ached for use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of Month 23d. Date									ery Day Year					
	requires that t been signed b should be deta	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions conditions contribute to the significant conditions contribute to the significant conditions conditi								1						
tal Reco	cian: The law ertificate has ector, page 2	Medical Certificate: To Be Compl	25. Was case referred to medical examiner?									mpletion of cause of					
Division of Vital Records, lal or Attending Physician: The law requires after death.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 Hours after death. To the Funeral Infector. After this certificate has been signed by the attending physician and Tro the Funeral Infector, page 2 should be detached for use as the burial-transit		1 Anpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special								d						
-	o the Hospit.		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause (s) and due to the								use(s) and manner stated stated.						
	- = -2		30. Name and addre	ss of person who	completed cause of c		23a) (Type, P		p	7014	14					27,2012 D20450	
	Sta Registr		31. Date filed (Month	B 09 20	12 Registr	ar's Signatu	901 h	rint) Nedi	cal	بلان	r D	r Ki	ck	Ville	· rv	J 20150	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 11, 2012 10:00 A MARY ANN COURSEY CASEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **OUEEN ANNE'S** 1630 BARCLAY ROAD BARCLAY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Mir 83 Yrs **Director** 222-18-0115 05/30/1928 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c City Town or Location 10d. Inside City Limits Director 1 Xyes 2 No MARYLAND QUEEN ANNE'S BARCLAY 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1630 BARCLAY ROAD UNITED STATES filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify Specify. Completed 3 X Widowed 4 Divorced WHITE er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 FOOD SERVICE CAFETERIA WORKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be ment of Health and Ments CHARLES ELWOOD COURSEY **EVA SKINNER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. TAMMY OSBORN / DAUGHTER P.O. BOX 91 BARCLAY, MARYLAND 21607 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEM. 02/16/2012 SUDLERSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. B70 W. CYPRESS ST. MILLINGTON, MD 21651 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition eavs Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examiner Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe Coronary Ortery Disease 2 No 3 Probably 4 Unknown Completed page 2 should Dyshpidemia, tenting, 24b. Were autopsy findings available prior to completion of cause of tension, 24a. Was an has autopsy performe death? certificate Dementia ☐ Yes 2 N 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1. Natural work? 1 Yes 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Rm State

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within 24 hours a To the Hospital

Medical

29a. Certifier (Check

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1

FEB

29b. Signature and title of certific

31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009 ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2/4/2012 Nellie Catherine Clark 11am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Marley Neck Nursing & Rehab Glen Burnie 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2XCXF Months 220-05-3783 92 Yrs Director Usual Residence of Decedent or 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2xXNo Gambrills MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 1015 Annapolis RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 XX Mo Maryland 21215-0036 White If Yes Give 1 Yes XX No Specify: Completed 3x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be be a Department of Health and Mental Important: If item 27 is marking or other? ပ George F. Moss Annie Pauline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gambrills, MD 21054 1015 Annapolis Rd. Gerald Hnyla Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baldwin U.M. Cemetery 2/10/2012 Millersville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line 2nset y Immediate Cause (Final TERIO-SCLE Physician/ KOI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Due to (or sele consequence or) the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phy 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 \sum Yes 2 \sum No 1 Latural 5 Pending Investigation Accident Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Hou Shi Chen February 2, 2012 8:20A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4307 Josephine Avenue Beltsville Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 537-34-0788 91 Months Days Hours Min. OCC th, 7°, 1°920 Nanking, China Director Usual Residence of Decedent ital Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4307 Josephine Avenue 20705 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 77 Black, White, etc 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Asian If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) United States Dept. of College (1-4 or 5+) Elementary/Seconday (0-12) Research Scientist Agriculture permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Yea Tsung Chen Yuan Chen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ming Yee Chen -wife 4307 Josephine Avenue Beltsville, Maryland 20705 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory2/3/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonard VoreBofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 10 years Immediate Cause (Final Physician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pressure ulcers 6 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Cun ta for as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No certificate ! death? 1 🗌 Yes 2 🖾 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 XNo Other: 1 Tes 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A:

Completed filled in by the fu death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar

only one) 29b. Signature and title of cert

Sean S. Sædi,

M.D.11120 New Hampshire Avenue, #305 Silver Spring, Maryland 20904 Registrar's Signat

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Sean

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0_60359

29d. Date signed (Month, Day, Year)

February 3, 2012

29c, License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20, Day 2012 8:37 Edith Lang Clark Ρ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11505 Gainsborough Rd. Potomac Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Ye October 17, 1 M 2 X F Hours Year) 1925 New York Director 119-18-9605 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shortanmatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Potomac 1 Yes 2 K No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11505 Gainsborough Rd. 20854 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Litovitz Esther Lubetkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Elisa L. Clark - Daughter 11505 Gainsborough Rd. Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David 01/22/2012 Falls Church, VA 22. Name and Address of Facility M 00 National Funeral Home 7482 Lee Highway Falls Church,VA 22042 23a. Cart T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final set and Death Ph sician/ ALZHEIMER'S disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir The law requires that the death certificate be executed and -train Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 X No g | Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 Yes 2 No Yes 2 🗶 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 K Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Notice with the following states after death.

To the Funeral Director: After the funeral by the funeral following states and the funeral fune Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifie 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of ex (Check nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/2 D09834 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Ave. Kensington, MD 20895 Barry Rosenbaum State

Registrar

06 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-01054 State of Maryland / Department of Health and Mental Hygiene Michele Lee Carter 2012 05606 1- For State Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day February 4, 2012 1506 hrs **Medical Examiner** MICHELE LEE CARTER 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (if not institution, give street and number) 1 Montgomery Montgomery General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Hours Director 07/23/1959 215-72-7763 52 Country) [VID 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 Yes 2 No Brookville Montgomery Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother transatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20215 Georgia Avenue, #1 20833 **USA** Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Bus Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin E. Carter Pearl Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20215 Georgia Avenue, #3, Brookville, MD 20833 Dasery Jaray Carter/son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Svc | 02/20/2012 Hanover, MD Donation 5 Other Specify; 22. Name and Address of Facility Snowden Funeral Home 21. Sign are of Funeral Servi 246 N. Washington St, Rockville, MD 20850 23a. Part I. Enter the direase, or complications that caused the de in. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Acute subarachnoid Hemorrhage secondary to ruptured Aneurysm of the Between Onset and /Medical Death aright middle cerebral artery with extension into the basal forebrain Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Ga attending physician i X UNPENDED AMENDED 23a, 27, per me, g_{926} 4-12-12 sm Physician/Medi The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. δ 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been si , page 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 Yes certificate the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA this 1 Yes After th 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No 5 Pending Director: Investigation 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. February 5, 2012 30. Name and address of person who completed cause of death (Item 23a) when M.

31. Date filed (Month, Day, Year) Registrar

Theodore M. King, Jr., MD.

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

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. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Day 2012 Physician/ FEBRUARY 2:44 P RENEE CRUTCHFIELD KAREN Medical 4a. Facility Name (if not institution, give street and number FREDERICK MEMORIAL HO 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL FREDRICK Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) **Director** 1 □ M 2 🔀 F 219-76-5693 52 12/13/1959 MD Usual Residence of Dece 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1313 Motter Avenue 21702 U.S.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. "natural", 3 Divorced 4 Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier-Dunking Donuts Foodservice other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stanley Jackson Patricia A. Crutchfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9515 Fingerboard Rd., Ijamsville, MD Tamara Lyles/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematory 2/8/2012 Hanover, MD 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Snowden Funeral Home, P.A. M4576 Sle 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ hyporanic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner phermonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Transit Exami The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year ed by the a detached i 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 this certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2. No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funer of the function of the funer of the funer of the funer of the funer of the function of the functi 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier

only one)

3 [

cns

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Telf Comina with MO (W) W) H A F

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Physician/ 1310 Chan H. Choi 05. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 1418 Casino Circle Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-82-9279 **Director** 1 🗆 M 2 🕱 F 74 Yrs 10/05/1937 Korea Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō Examiner must be items 23a Funeral 20906 u.S.A. 1418 Casino Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Asian Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Owner/Operator 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or cet. ပ္ Nan Y. Lee Hoon S. Park 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jason J. Choi - Son 12789 Victory Lakes Loop, Bristow, Virginia 20136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Unitersity 1 Burial 2 Cremation 3 Removal from State 02/10/2012 Bethesda, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death the s Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After work? injury 1 🔀 Natural 5 Pending 2 No Investigation Accident completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier The Certifying Priystatin: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sla ture and title of certifie

State Registrar

DHMH 17 Bev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 \mathbf{A} M 4:15 Bibi Zubida Conliffe February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14327 Georgia Avenue #203 Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Funeral Age (In yrs. last birthday) (Month, Day, Hours Min Director 1 □ M 2 🕱 F 52 Guyana 220-77-2446 July 6,1959 Yrs Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director or 28a-f 1 Yes 2 X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 14327 Georgia Avenue #203 20906 Guyana or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: East Indian and Mental Hygiene. is marked other than "natural", 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aquatic Center Swimming Coach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other. Abdool Khayum Zabeeda Mohammed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090619a. Informant's Name/Relationship (Type, Print) 14327 Georgia Avenue, #203, Silver Spring, MD Howell M. Conliffe(Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
A1-Firdaus
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State February 10, 2012 4 Donation 5 Other (Specify) Frederick, MD Gardens 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, 21. Signature of Funeral Service Licenses RACY A STUVESO. M01117 Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cervical Cancer with Metastases Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) D To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-Epecit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 X No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: မ 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 😾 Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b, Signature an 29d. Date signed (Month, Day, Year) D37142 February 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

Year,

08 2012

. Registrar's Sign

Geoffrey Coleman, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 Billie Joyce 10:15 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. If Under 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Virginia 01708/1937 224-46-6263 75 Director Usual Residence of Decedent 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits Director Huntingtown 1 Yes 2 X No Calvert MD 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 326 20639 Armiger Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clinton Myers Virginia Radcliff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once. E. Clinton Cox, Sr. 326 Armiger Road, Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 02/11/2012 | Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follows. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 1000 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** -10 dayk Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hydrocephaly Pressure Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has perform 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: 2 1. XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Funeral Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of certifier 0027189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2417 Selmons Island 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STEPHEN CELEY FEBRUARY 20129:07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2 □ F Months DC Director 577-92-4026 46 August 5. 1965 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ▼ Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Holbrook Street, NE 1713 20002 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Black. 3 Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Cooking Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ William Henry Celey Patricia Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Celey/Mother 1713 Holbrook Street, NE, Wash., DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Cedar Hill Cemetery 2-11-2012 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Serv Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastate lung concer Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Recorrect asportation preumone Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed Falluratitine | chronic novarious that initiated events Due to (or as a consequence of) resulting in death) Last attending physician of for use as the burial-Physician/Medical VIUS acquired immunidel-syndrov Humanimmunodefictory Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No 1 Yes 2 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, cate has been sig page 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 Yes Yes of Vital within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury Division 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

sup im

Stephen Migueles 31. Date filed (Month, Day, Year)

9 201

010105246

10 CENTER DRIVE, BETHESDA, MD

29d. Date signed (Month, Day, Year) 02/06/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of M	larylan	d / Depa	artment o	f Healt	h and I	Mental Hy	giene			
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Maryland 21215-0036	2 sho th an 27 is trau		19a. Informant's Name/Relationship (Victoria M. Colbe	** *	ter	1				al Route Number Landov	-			1
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Ë	Page tent o int: If		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		, ce	emetery, crem Harmo	natory`or other	olace)	Febru	ary 10, 2012		•	Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	isee 0 1	1			dress of Fa		ewart Fu				
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687	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	ICV								
P.O. Box 687	atten atten for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a	2 🗌 Fetal	death 3	Ectopic pregr				2	3d. Date of de Month	livery Day Year	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ LOSTEV even 2241PM Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death riv OTHIAN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min 08/04/1946 Director 579-58-4903 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Anne Arundel Lothian 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Decesaris Drive 20711 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates. Navy Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Upholstery Self Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alfred Chester Betty Jane Gatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Chester/Wife 901 Decearis Drive, Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Lee Crematory 02/10/2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Signal of uneral Sen Lisa M. Mounts M01516 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ teriosclerotic 15CHS-L disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 12 Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No 1 Yes 2 Unknown Yes the Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ျပ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signaty 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ 102-10-2012 1630 PM Catherine P. Calder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford Four Season Assited Living Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min Days 07/27/1922 218/14/5859 Director 1 🗆 M 2 🔀 F Maryland 89 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Harford Havre de Grace Marvland 10e. Street and Number 10a. Citizen of What Country? Funeral 21078 UnitedStatesofAmerida 746 Tydings Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forc Black White etc. þ 1 Never Married 2 Married 2X No Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 ₩ Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Secretary Clerical Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmer Street Blanche Wilder traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (son) Archer Franklin .O. Box 752 Havre de Grace, Maryland 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 02/13/2012 W.CHester, 4 Donation 5 Other (Specify) Ferris & of Funeral Service License 22. Name and Address of Facility Zellman Funeral Home, p.a. grati Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only see all Approximate Onset and Death Immediate Cause (Final HypoxIA Ph_{sician/} SECON disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a coverquence of) Exami and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical requires that the death certificate be Box 68760 as the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown Pregnant at time of death Unknown P.0. signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 autopsy performed Yes 2 certificate has 2 No 1 Yes 25. Was case referred to medica Division of Vital director, Be 26. Place of Death (Check only one) examiner? Hospital: Jos 12 Jed Other: 1 🗌 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this Director: After this d in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending death. 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

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Name and address of person who completed cause of death (Item 23a) (Type, Print

ANUSHA SIRITHARA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Coffinberger _Month Physician/ Bradley i-ebrua 4,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown washington Meritus Medical Center Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 234-02-6813 54 Director 1 X M 2 □ F 10/29/1957 WEST VIRGINIA Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director W۷ BERKELEY MARTINSBURG 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 253 BROOKDALE AVENUE 25401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 【☐ No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) CATERING Elementary/Secondary (0-12) College (1-4 or 5+) OWNER/OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EVELYN CAMMER JOHN H. COFFINBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN COFFINBERGER/MOTHER 253 BROOKDALE AVE., MARTINSBURG, WV 25401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Caremation 3 Removal from State SMITHSBURG CREMATORY SMITHSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Multiple organ failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** septic shock Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Fulminent colitis the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Difficile Clostri dium Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anuric renal failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ventilator dependent respiratory failure 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Metabolic acidosis obesity Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D46081

Registrar

DHMH 17 Rev 06-201

State

242 Robin Wood Professional Center

Hagerstown MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Mary Evelyn Cannon Ph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Unde 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 218-16-4193 Director 1 🗆 M 2 🗶 F 86 October 12, 1925 Maryland Usual Residence of Decedent items 23a or 28a-f show ner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15404 Warnick Road 21532 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner or. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. "natural", 3 Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance Worker County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill trument of Health and Mental virtant; If item 27 is marked o Charles Beeman Martha McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Drew - Daughter 15408 Warnick Road, Frostburg Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important; If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel February 17 Cumberland Crematory 4 Donation 5 Other (Specify) 2012 Cumberland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Dond 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Ph sician/ Mus Carolio disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۸q Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform certificate Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျှ 1 Department 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify funeral Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLOW Brook 00 State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name	e (First, Middle,	Last)				Dear		2. Date of De		£ U	1-4	3. Time of Death
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Examir	er	5204 Batt	ery Lar				4b. City, Town Bethes	da				c. County of E Montgor		
Funeral Director		5. Social Security No. 218-24-0 Usual Residence of	0794	6. Sex 1 □ M 2 1 F	7. Age (In yrs. 103	last birthday) Yrs.	_If Under 1 Ye Months Da		rs Min.	8. Date of Bir (Month, Da 07/14/	ay, Year)		Country	nce (State or Foreign r) ngton, DC
aryland a-f show ffied at	Director	10a. State MD	10b. County Montgo	mery		ty, Town or Lo	cation						100	d. Inside City Limits 1 2 Yes 2 □ No
with the M 23a or 28 ist be not	eral Dir	10e. Street and Nur 5204 Bat		ıne			10f. Zip Coo				_	itizen of What		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ances.	ed by Funeral	11. Marital Status 1 ☐ Never Marr 3 🛣 Widowed	ied 2 🗆 Marri	12. Was Deced	ces? 2 X No		Was Decedent of Yes, specify C	uban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W Specify: Wh	/hite, etc	c.
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Page 1 arment of He tant: If iter		20a. Method of Disp 1 Burial 2 4 Donation		3 ☐ Removal from Specify)	State	cemetery, crer.	sition (Name of natory or other of Cremat		i	Date / 2012		Location - City 11s Chu		
permit Depar Impor any in once.		21. Signature of Ful	neral Service Li	Be						eph Gaw				
Physician/ Medical Examiner	_	23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failūre. List or Final n	Due to (o	used the dea h line. Failuras a conseq Lc Ster	ire	er the mode of a	lying, such	as cardiac (or respiratory ar	rrest,		1 1	Approximate nterval Between Onset and Death
cate be executed physician and sthe burial transit	edical Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate rlying injury s	c	r as a conseq									
ath certifii attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ g ☐ Unknown	months?		irth 2 Fet ant at time of	al death 3	Ectopic pregr Other (specify					23d. Date of Month		/ ay Year
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r The law req cate has bee r, page 2 sho	Completed									1 Yes	psy ormed?	prior death	to comp	y findings available oletion of cause of
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the Hospital or Attenc nin 24 hours after death the Funeral Director: npletely filled in by the		3 ∐ Suicide 4 □ Homicide	6 ∐ Could n determir	28e. Place o	of Injury - At h	ome, farm, stre	eet, factory, offi	ce		28f. Location (S City or Tov			Rural R	oute Number,
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with 5 of 0				Bennett	M		IV		3041	9	29d. D.	ate signed (Mo	ontn, Da	y, rear)
		Susan Be	nnett M	ho completed cause D 2131 K	Street	NW Su	Lte 800	Wash	ingto	n, DC 20	0037	7		
Star Registra		31. Date filed (Monti	n, Day, Year) 0 9 20	12 Pen	gistrar's Signa	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evaristo Feb. 5, 2012 De Leon 2115 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 213-29-2991 Days Hours 81 1²713/11930 **Director** Dominican Rep 1**₹**1 M 2 □ F Usual Residence of Decedent show or 28a-f shov notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 4623 Glasgow Drive 20853 Dominican Rep. items ? Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Dominican

XYes 2 \(\t \) No Specify: 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? i "natural", or iten edical Examiner i 14. Race - American Indian Black White, etc. Black þ 1 Never Married 2 Married Yes, Give 2 X No Baltimore, Maryland 21215-0036 Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix De Leon ဂ Julia Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irinelda Blandon/Daughter 12654 Willow Spring Court Herndon, Va. 20170 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . = .º 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Department of Important: If any injury or 2/11/2012 Annandale, Va. 4 Donation 5 Other (Specify) uneral Service Li HNDIP PRIMALDI FUNERAL SERVICE, P.A. 241 Columbia Blvd.Silver Spring, Md20910 Signatin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Hepatocellular carcinoma Medical Due to (or as a consequence of) Examiner Liver cirrhosis So quenticity list on diffuse if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Day Year 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ multi-organ failure Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: ⁷ within 24 hours after death.

To the Funeral Director; After this certifici Соmpletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063343 Feb. 6, 2012

State Registrar 31. Date filed (Month, Day, Year)

Irina Ruban MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Drive Silver Spring, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#23a(b-Ders) Dervisor MD, 2/21/12: HWW MOO Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mooth												
Physici			De Febbo					3. Time of Death 1910 M					
Medi Exami		4a. Facility Name (if not institution, give street and			Location of Death	1	4c. County o						
<u> </u>		Washington Advent: 5. Social Security Number 6. Sex	ist 7. Age (In yrs. last birthday		ma Park	8. Date of Birth		gomery					
Funeral Director		179-38-3005 1□M2□		Months Days	Hours Min.	9 Month 9 4	939	9. Birthplace (State or Foreign Country) PA					
and show	ē	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits					
Maryl 28a-f notified	Jirect	PA Carbon		Lansford				1 ^X Yes 2 ☐ No					
with the	Funeral Director	10e. Street and Number 140 W.Kline Avenue	Э	10f. Zip Code 182	32	10	g. Citizen of WI U	hat Country?					
ING 21213-UU36 Ified within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 X Never Married 2 Married 1 If Yes	Decedent Ever in U.S. d Forces? Yes 2 No , Give or Dates.	I. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White					
Z7Z15-UU36 Within 72 hours after giene. er than "natural", o the Medical Exam	Completed by	15. Decedent's Education (Specify only highest grade comple	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired)		king 1	6b. Kind of Bus	iness Industry					
Z1Z Z1Z within ygiene. her tha he, the N	Be Cor	8		Homemake	r		Own	Home					
	To B	17. Father's Name (First, Middle, Last) Monte De Febbo				ne (First, Middle, Ma ine Colo							
	1	19a. Informant's Name/Relationship (Type, Print) William De Febbo/I	Brother 19b. Ma	iling Address (Street a	and Number or Rui e Avenu	ral Route Number, C e Lans:	ity or Town, Sta ford , P	ate, Zip Code) A • 18232					
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Discemetery, cr	position (Name of ematory or other place iew Mem.	e) Cem,2/1	I .		City or Town, State					
Baltim permit. Pag Departmen Important: any injury		21. Signatur of Aperal Service Licensee	a	PHITATPART 9241 Col	RENALD umbia b	I FUNERALIVO.Sil	AL SER ver Sp	VICE, P.A ring, Md20910					
niile : :		23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause of Immediate Cause (Final	hat caused the death. Do not el on each line.	nter the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death					
Physician/ Medical Examiner		disease or condition resulting in death) a	e L (or as a consequence of):	fcuxur	6								
16 m	iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Statis post cl	nolecystec	tanv tub	e drainac	ie						
xecuted	Examiner	Cause (Disease or iinjury that initiated events c.	e to (or as a consequence of):	Cholycus	tostany :	tube and	Gallst	ME!					
ate be executed physician and the burial-transit	dical	d	Urinary Tract	Infection	-								
DIVISION OF VITAIL RECORDS, P.O. BOX 08/000 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director, page 2 should be detached for use as the burial-transition.	Physician/Me	in the past 12 months?		Cother (specify)	у		23d. Date Mont	of delivery th Day Year					
s that the	þ	Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause giv	ren in Part I.			bute to the cause of death?					
require require been sij	eted					1 ☐ Yes		3 ☐ Probably 4 ☐ Unknown ere autopsy findings available					
VITAI MECOLOS, ysician: The law require: is certificate has been si; director, page 2 should b	Completed					autopsy performed	ed? de	ior to completion of cause of eath?					
ician: Sertific ector,	æ	25. Was case referred to medical examiner?		Oth	ace of Death (Chec	k only one)							
OT V g Phys er this eral dir	e: To	27. Manner of Death 28a. [Inpatient 2 ER/Outpati	of 28c. Injury	4 ∟ Nursing H ⁄at	ome 5 Residen 28d. Describe how							
VISION OI or Attending Pl frer death. irrector; After th n by the funera	Certificate:	2 Accident Investigation	Month, Day, Year) injury		? Yes 2 □ No								
DIVIS al or At s after c al Direct		4 Homicide determined 28e. P	lace of Injury - At home, farm, s uilding, etc. (Specify)	treet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,					
UIVISION OF VITAL HECK the Hospital or Attending Physician: The law thin 24 hours after death. The Funeral Director: After this certificate has ampleted filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the Check only one) 1 Medical Examiner: On the Certifying Nurse Praction	basis of examination and/or inve	estigation, in my opinio	n, death occurred a	at the time, date and	place, and due t	to the cause(s) and manner stated.					
To the state of th		29b. Signature and title of certifier	_	29c. License	e number LUUI	29	d. Date signed ((Month, Day, Year)					
		30. Name and address of person who completed	cause of death (Item 23a) (Type	Print) Lylla	a Shahab,	M.D.	7	1 100					
Sta		31. Date filed (Mooth Day, Year) 31.	2. degistrar's Signature	Print) Lylla	u juni	c . /VI	<i>U</i> -						
Registr	ar	- LU 0 0 2012	anul 5. 14	arrive .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ellsworth DeBold Sr. Donald Physician/ reb. 12^{Day}2012^{ear} 11:35 A M Medical 4a. Facility Name (if not institution, give street and number)
15523 National Pike 4b. City, Town, or Location of Death Hagerstown 4c. County of Death
Washington **Examiner** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min 9-11-1923 MD (Guntry) 219-14-8885 1**X** M 2 □ F 88 **Director** 28a-f show 10c. City, Town or Location Hagerstown 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director MD Washington 1 Yes 2 X No 10e Street and Number 10f. Zip Code U.S.A. ö Citizen of What Country? 21740 items 23a Funeral 15523 National Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced WWII Completed artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natui injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) truck mfg.co. Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) cutter/grinder Be 7. Father's Name (First, Middle, Last)
William John DeBold ¹⁸ Mother's Name (First, Middle, Maidel Syrname) Katherine Matilda Naylor permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other 19a. Informant's Name/Relationship (Type, Print)

Donald DeBold Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 21740 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2-1^{Date}-2012 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Celli. Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Malignant Mesothelioma Immediate Cause (Final Physician/ 20 years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) ending physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an s certificate has be director, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred iniury spital or.
4 hours after de.
real Director: Ahc.
'n by the fir Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hou.. ***Te Funeral Dir.** ''v filled in bv determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2.

To the F
complet only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

TW-10+1 State

31. Date filed (Me Registrar

30. Name and address of person who completed cause of death (Item 23a) Type, Pr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Alvin James DeNoon February 6:05 p^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Williamsport 10837 Archer Lane Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 🛛 M 2 🗆 F 566-58-3569 August^{Day}10% Director Yrs Virginia 67 Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10837 Archer Lane 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☒No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Owner/Operator Landscaping Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Oscar DeNoon Clara Rose Ebbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10837 Archer Lane Williamsport, Maryland 21795 Anna L. DeNoon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory Feb. 14, 2012 Hagerstown, Maryland 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 000 enocarcinema disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page perform 2 No 2 🗌 No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the last of my knowledge, death occurred at the time, date and place, and due to the cause(s only one) 29b. Signature MD005212 2017 person who completed cause of death (Item 23a) (Type, Print) 6605

Registra DHMH 17 Rev 7/2009

State

Box 68760

Records,

Division of Vital

I2-01 Janus	370 z Duchnov		1- For State Certificate of Death								jiene					
	Physicia	n/	tegistrar 1. Decedent's Name					- Cale Oi	Dean			1	Date of De Month February	Day	Year 1	3 Time of Deeth 5 Z
Medi	cal Exami		JANUSZ 4a. Facility Name (if	DUCHN not institution		number)			4b. City, To		ocation of	_	Coluary	40	c. County of Death	
			200 Ariel Av			17 4	(laa. laat b	i atta day ()	Cecilto		If Under	24Hrs 1	8 Date of B		Cecil //DD/YYYY) 9. Bir	thplace (State or
	Funeral Director		5. Social Security N 155-90-		6. Sex		(In yrs. last b	Yrs	Months		_	1			Foreig	ountry) Poland
	any		Usual Residence of 10a. State	Decedent 10b. County		1	0c. City, Tov	wn or Locat	tion							10d. Inside City Limits
	ie i	٦	MD	Ceci	1	-	Cec	ilton								1 XYes 2 No
	te Maryland or 28a-f show fied at ooce.	Director	10e. Street and Nun						10f. Zip	^{Code} 1913				•	tizen of What Cou land	ntry?
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand and Mental Hygievie Department of Hand and Mental Hygievie Important: If item 71 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be ootiffed at occ.		200 Arie		12. Was D Armed	Forces?	ver in U.S.	13. Wa		nt of Hisp	anic Origii	n? (Spec Puerto Ri	cify Yes or N			ican Indian, Black,
	ffer de 17°, or i	y Fu	3 Widowed		1 Yes	ear	No		Yes 2						Specify:	White
	hours a natura Examir	ed by	15. Decedent's Ed		cify only highest g	ade comp		a. Deceder during m	nt's Usual on nost of wor	Occupation	on (Give ki DO NOT u	ind of wor use retired	rk done d)		Kind of Business	
9	hin 72 e. than "	Completed	Elementary/Seco	ndary (U-12)	Conege	(1-401 54		Auto	Mecha					- 1	uto Repa	ir
1	21215-0036 wild be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (•				-		1			irst, Middle Modze		n Surname) ka	
	2121 ald be fi Mental marked	To Be	UNKN 19a, Informant's Na		Ouchnowsk	<u> </u>	Т	19b. Mailin	ng Address	(Street	and Numb	ber or Rur	ral Route N	umber, (City or Town, State	e, Zip Code)
	MD and 2 shot m 27 is aumatic		Edyta D		rski (w	ife)			Arie						21913 Location - City o	r Town State
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 1									alena, M						
	Baltin permit. P. Departne Importan injury or		21. diponation 5			M	00510	22.	Name and	Address	of Facility neral	Home	e of S	Step	hen L. S MD. 2163	Schaech 35
	Physician Medical		23a Part I. Enter th	ne disease, only one cause	r complications that e on each line.	t caused t	he death. Do	not enter	the mode	of dying,	such as ca	ardiac or r	espiratory a	arrest, si	hock, or heart	Approximate Interval Between Onset and Death
	xaminer		Immediate Cause (or condition resulting		a. Hanging Due to (or a	s a consec	quence of):									
		ner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	b Due to (or a	s a conse	quence of):									
	cuted ind transit	Examiner	(Disease or injury t events resulting in	that initiated death) Last	Due to (or a	s a conse	quence of):									
	execute ian and ial - tran	ical	UNPENDED	1	AMENDE	D										
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuecral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	<u> ਬੁੱ</u>	IF FEMALE: 23b. Was decedent past 12 months	s?	the 1 Liv	e birth egnant at t	e of pregnar	2 🔲 F	etal death Other (Spe	3 [cify)	Ectopic	pregnan	су	2	3d. Date of delive Month	ry Day Year
	that the death ned by the att detached for	Physic	Part II. Other sign		9 0	known g to death	but not resu	ulting in the	underlying	cause g	iven in Pa	nrt I.				o the cause of death?
	S, P.(quires tha en signed ald be det	ted by											24a. W	as an	1 24b. Were a	obably 4 Unknown autopsy findings available
	(ecord he law rec ate has be age 2 shou	Completed	autopsy performed? 1 Yes 2 ✓ No 1 Yes													
	tal R clao: T certific ector, p	BeC	25. Was case reference examiner?	rred to medic	al Hospital:	7		R/Outpatie			of Death		nly one) Home 5	Resi	idence 6 🗸 Oth	er: Scene
	in of Vital Records, P.O. ing Physiciae: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	n: To	1 ✓ Yes 27. Manner of Dea 1 Natural		28a. D	Inpatien ate of Injurenth, Day,Yo	√ 12	8b. Time o		28c. Inju	ry at Work res 2 ✔	? 2		oe how i	injury occurred	
	Division of Vital Records, P.O. To the Hospital or Attending Physiciae: The law requires that twithin 24 hours after death. To the Fuoeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detae.	Certification	2 Accident 3 Suicide 4 Homicide	6 Co	estigation Feb uld not be	15, 2012 Place of Inj	ury - At hom					tc. 2	or Town	1 State		Rural Route Number, City
	the Hospit in 24 hour the Fuoer:	lical Ce	29a. Certifier (Check only one) 2		Physician: To the caminer: On the ba	best of my	/ knowledge	death occ	curred at th	e time, da y opinion	ate and pla , death oc	ace, and o	due to the c	ause(s) ate and	and manner as st place, and due to	ated. the cause(s)
	To T	Medi	29b. Signature any	· .	and mann	er stated.			29		e number				d. Date signed (A	
	2		111	ule	allel)		at- (0)	2-1		O.C.	M.E.			F	ebruary 16, 20	U12
	ms		30. Name and add		on who completed Assistant Med	cause of d	eath (Item 2 aminer	за) 900 W. I			t, Baltin	nore, N	1D 21223	3		
	5	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, 1997) 32. Register's Signature														

State Registrar

UUIWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last)

Physician
/Medical Examiner
LXamino

Month 7:23 P 8, 2012 LINWOOD February RODNEY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Crisfield Somerset 108 Columbia Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days 1 **34**M 2 □ F Maryland 217-34-5714 Director 10/10/1935 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show or than "natural", or items 23a or 28a-f show the Medical Experience must be notified at 1 ☑ Yes 2 ☐ No Crisfield Maryland Somerset Director within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21817 108 Columbia Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other trammer. Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addie F. Evans Rodney W. Dize 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Columbia Avenue - Crisfield, MD 21817

of Disposition (Name of Date 20c. Location - City or Town, State Kay L. Dize (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Peters Church Cem. 02/11/2012 Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Scheral Service Lice Pobert H. Bradsky MD 21817 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Osset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. detached 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 🛣 No 1 ☐Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012 BARAL; MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, PT)nt) MD 604-Mar Ke T 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	lental Hygie	ene	05001
				rtificate of Death	Reg	1. No. 2012	05621
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Medic	cal	BARBARA ANNE DARLIN 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	JAN.	25, 2012	9:15 P M
	Examin	ier	MANOR CARE NURSING HOME	SILVER SPRING		4c. County of Death MONTGO	MEDV
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	lace (State or Foreign
н	Director		353-10-8067 1 □ M 2 🛣 F 94 Yrs.	Months Days Hours Min.	(Month, Day, Ye MARCH 2,	1917 KA	NSAS
	show dat	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature	ocation		1	0d. Inside City Limits
	//aryla 8a-f s tified	Director	MD. MONTGOMERY	SILVER SPRING			1 😾 Yes 2 □ No
	the N	Ö	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	itry?
	a filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral	2501 MUSGROVE RD.	20904		U.S.A.	
	r item iner r		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
936	s after al", o Exam	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: WHI	
2	hours matur dical	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	Bb. Kind of Business Inc	
21	nin 72 he. han " e Med	mo duo		kind of work done during most of worki OO NOT use retired)	ng		
22	d with their int, th	BeC	17 Fether's Name (First Middle Leaf)	HOMEMAKER		HOME	
and		10	17. Father's Name (First, Middle, Last) DOMENICO BORGOGNI		e (First, Middle, Maio MARIA	PASOUETI	
ary.	should and Me is mar raumati			ing Address (Street and Number or Rura			Code)
Σ	ひ中です			1 INTERLACHEN DR.			
ore	. 0		20a. Method of Disposition 20b. Place of Disp			c. Location - City or To	
<u>Ē</u> ,	Page tment o tant: If jury or		4 Donation 5 Other (Specify) CHAMBERS	CREMATORY 1-30-	-2012	RIVERDALE	, MD.
Baltimore, Maryland 21215-0036	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee MO0091	2. Name and Address of Facility HAMBERS FUNERAL HO 801 CLEVELAND AVE	OME & CRE	MATORIUM,P ALE, MD. 2	o 737
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between
P	nysician/	8	Immediate Cause (Final disease or condition resulting in death)				Onset and Death
-	Medical Examiner		Due to (or as a consequence of):				
H		Jer	Sequentially list conditions, b. HYPERTENSION if any, leading to immediate Due to (or as a consequence of):				
1	- B	Examiner	Cause Disease or injury that initiated events	CCIDENT			
	outificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial to	E	resulting in death) Last Due to (or as a consequence of):				
۶ و	the bu	dical	d				
289	ding p	/Me	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy				
180 X 08 /	atten	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
. E	by the	hysi	9 Unknown				
Hecords, P.O.	ned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
or Vital Records,	d pind p	ted	OSTEOPOROSIS		1 🗆 Yes	2 No 3 Prob	pably 4X Unknown
Co	iaw ie ias be i 2 sho	Completed			24a. Was an autopsy	prior to co	sy findings available npletion of cause of
å å	cate h				performed	d? death? ☐ No 1 ☐ Yes	2 🗆 No
Iza Iza	certifi	Be	25. Was case referred to medical examiner?	26. Place of Death (Check			
> 10	r this gral di	e: To	1 ☐ Yes 2 🟋 No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death	11 3 1 BOA 4 23 Nursing Ho	me 5 Residence 8d. Describe how i	e 6 Other (Specify,	
on c	ath. r: Afte re fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	our booonso now .	rijary oddarrod	
DIVISION	recto	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural	Route Number,
בֿ בֿ	urs aft						
H of	within 24 hours after death. To the Funeral Director: After this certific Completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 2 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and p	lace, and due to the cau	se(s) and manner stated.
	20		29b. Signature and title of certifier Office Military Mi	29c. License number D20274		JAN. 27, 2	
			30. Name and address of person who completed cause of death (Item 23a) (Type, I				
			KIRTI VOHRA, M.D. 7710 BRADL 31. Date filed (Month, Day, Year) 32/Registrar's Signature	EY BLVD., BETHESDA	MD. 20	817	
	Stat Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Med.			
рнмі	H 17 Rev 7/20	na	The state of the s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February Physician/ 5:25 A M 2012 Felipa Juarez de Lara Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 578-17-1731 Director 1 □ M 2**X** F 79 9/13/1932 ElSalvador Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b County 10c City Town or Location Director notified 28a-f 1X Yes 2 ☐ No MD Prince George's Hyattsville 10g. Citizen of What Country? 6 10e. Street and Numbe ms 23a or must be Funeral 9030 Continental Place 20785 Salvador iral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Salvadorian white "natural" Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene.

If item 27 is marked other than "r
orther traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) self employed homemaker 4th Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jose Maria Reyes Valentina Juarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosario Lara Juarez(daugh) 9030 Continental Pl., Hyattsville, MD 20785 E If item? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stat Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 X Removal from State El Salvador Salvad 2/15/12 | El Salvad Address of Facility W. H. Bacon, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 3447 14th St, N.W., Washington, DC, 20010 landa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Directo (or as a nonsequence of) day, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last as the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 ☐ Fetal deatPregnant at time of death in the past 12 months? Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CIRRHOSIS 1 Yes 2 No 3 Probably 4 Unknown Stage Liver Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy Myelodysplastic Disease Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide s after death. the f Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number M 061552 02-01-12 Recompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person v Luck ROAD, LANHAM, MD 20706

DHMH 17 Rev 06-2011

Registrar

State

Kev

31. Date filed (Month, Day, Year)

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		-	For State Registrar	State of Marylan		artment of H tificate of D			giene _{Reg. No.} 2 (112	05626
	Dhamiaia	/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Voor	3. Time of Death
	Physicia Medio	al	Mary Patricia	Durkin				Februar	-	012 Year	5:15 p ^M
	Examin	er	4a. Facility Name (if not institution, give stre Montgomery Hospice-			4b. City, Town, or Rockv1		eath		y of Death tgome 1	-v
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birt	h		lace (State or Foreign
	Director			M 2 🖾 F	Yrs.	Months Days	Hours W	July 13			ngton, DC
	and show l at	o.	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	cation	<u> </u>		<u> </u>		Od. Inside City Limits
	Maryl 28a-f otifiec	irect	MD Montgo	mery	Silv	er Spring	5				1 Yes 2 No
	ith the 3a or t be n	Funeral Director	10e. Street and Number 3805 Woodridge Av	enite		10f. Zip Code 20902			10g. Citizen of USA	What Coun	try?
	ems 2	-une		. Was Decedent Ever in U.S	. 13. V		spanic Origin?	(Specify Yes or No- lerto Rican, etc.)		ce - America	an Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed Forces? 1 ☐ Yes 2¾☐ No If Yes, Give Year or Dates.	1	Yes, specify Cubar		erto Rican, etc.)	Bla Specif	white, e	etc.
15-(72 hou n "nat ledica	Completed	15. Decedent's Educa (Specify only highest grade)	completed)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired)	ation Juring most of v	working	16b. Kind of I	Business/Inc	lustry
212	ed within Hygiene. other tha		Elementary/Secondary (0-12)	College (1-4 or 5+)		erior Des	igner		Interi	or De	sign
pu	filed tal Hyge of other event,	To Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		ne)	
ryla	2 should be file lith and Mental H 27 is marked or r traumatic ever	-	Jeremiah Thomas C 19a. Informant's Name/Relationship (Type,		10. 14.35			Frances H		Chata Zia C	la efa)
Ma	and 2 sho Health an tem 27 is other trau		Kathryn E. Cuff/Da	·				nsington,			ode)
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cren	sition (Name of natory or other place can Cremat		Feb. 3,	20c. Location	•	
Balti	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee	5 MO1503	F ²² 50	Name and Addres ancis J. O Univers	çollun sity Bl	s Funeral	Home I ilver S	nc. pring	, MD 20901
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications of the complete shock in the complete shock is the complete shock of the complete shock in the comple	tions that caused the death ause on each line.	. Do not ente	er the mode of dying	g, such as card	diac or respiratory an	rest,		Approximate Interval Between
	h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Uterine Canc						-	Onset and Death
	Examiner			Due to (or as a consequ	епсе от):						
	- - √	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
	and and	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					-	<u> </u>
0	icate be executed in the purial factor is the burial factor is the buria	edical	d.								
8760	ifficate ng phy as the	Med	IF FEMALE:								
. Box 68	that the death certificate be executed red by the attending physician and a detached for use as the burial most	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnar Live Birth 2 Feta Pregnant at time of d Unknown	death 3	Ectopic pregnancy Other (specify)	у			ate of delive	ory Day Year
P.O.	that the	by Pl	Part II. Other significant conditions contri	buting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cor	ntribute to th	e cause of death?
rds,	v requires that s been signed to should be det	ted						_ 1 🗆			pably 4 🗆 Unknown
of Vital Records,	The lav ate has page 2	Completed						24a. Was perfo 1 □ Yes	osy rmed?	. Were autop prior to cor death? 1 \(\subseteq \text{Yes}	osy findings available inpletion of cause of
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1		Othe	r	Check only one)	жНо	spice	
0	ding Phys h. After this funeral d		27. Manner of Death 1 X Natural 5 Pending		28b. Time of injury	28c. Injury work	at ?	28d. Describe h			
Division	Attending Pher death. ector: Affer the by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm stre		Yes 2 No	28f. Location (S	Stroot and Num	her or Rural	Poute Number
) į į	al or A s after Il Direct		4 Homicide determined	building, etc. (Specify)		30t, 140tory, 011100		City or Tow		oci oi ribiei	nodic realison,
	io the Hospital or Attend vithin 24 hours after death to the Funeral Director: A completely filled in by the f	Medical	(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination ractitioner: To the best of m	and/or invest	tigation, in my opinio	n, death occurr	red at the time, date a	ind place, and d	ue to the cau	ise(s) and manner stated.
	within 2 To the Comple		29b. Signature and title of certifier	heten .	CRNI	P 29c. License R143			29d. Date sign.	ed (Month, D	Day, Year)
_			30. Name and address of person who com Debrah Miller, CRNI				ckville	e, MD 2085	50	1	
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 6 2012	2. Registrar's Signat	ure for	es.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	_ State	ate of Marylan		artment of H tificate of D		, ,	ene g. No. 2 A	2 05627
		,	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death	- 	3. Time of Death
ш	Physicia Medic	al		Louise Doy	le			Februa		12 10:45 am
	Examin	er	4a. Facility Name (if not institution, give street a Holy Cross Hos				Location of Death Ever Spri	иа	4c. County of De	ntgomery
TATE OF	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. E	Birthplace (State or Foreign
	Director		217-18-8208 1 □ M 2 Usual Residence of Decedent	TXF 8	7 Yrs.	Months	Tiodis Will.	08/28/		Maryland
	and show lat	5	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryla 28a-f otifiec	irect	Maryland Montgomer	.y			lver Spr			1 🗌 Yes 2 🎗 No
	th the	al D	10e. Street and Number			10f. Zip Code	0.0002	10	0g. Citizen of What	
	ath wi	Funeral Director	10300 Royal Road 11. Marital Status 12. We	as Decedent Ever in U.	S. 13. V	Was Decedent of His	20903 spanic Origin? (Spe	ecify Yes or No-		U.S.A. perican Indian,
Maryland 21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at the Medical Examiner.	à	1 Never Married 2 X Married 1 If	med Forces? □ Yes 2 🗶 No Yes, Give ar or Dates.	l l	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh Specify:	
5-0	2 hour	plet	15. Decedent's Education (Specify only highest grade com		(Give i	dent's Usual Occupa kind of work done d		ing 1	16b. Kind of Busines	ss/Industry
121	ithin 7	Completed	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	Ìife. D	O NOT use retired) Homen	nakon		0	wn Home
d 2	2 2 4 5	Be	17. Father's Name (First, Middle, Last)			1.011.011		e (First, Middle, Ma		
ylar	should be file and Mental H is marked o raumatic eve	입	Frank Nor	wood Starn	_			0.0	ie Fox	
Mar	2 should be Ith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type, Prin		1				City or Town, State, . g, Maryla	
	and Hea em the		Mahlon Doyle - Spo 20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of			20c. Location - City	
mo	Page nent o ant: If iry or		1 X Burial 2 ☐ Cremation 3 X Remove 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place 2metery	02/0	7/2012	Sycamore.	. Ohio
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signative of Tune & Service Ligensee	a M0124						al Home, Inc. ing.MD 20904
			23a. Part Enter the disease, or complication shock, or heart failure. List only one caus	is that caused the deat e on each line.	h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	Respirat Due to (or as a conseq	ory Fa	ilure				Onset and Death
1	Examiner		Toolang in doday			Obstruct	ino Dulim	avatu Di	10010	
	_	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq		. Obsolute	LUE TUSH	orabed exc	36.006	
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Box	e deat the at thed fo	ysici	1 Ves 2 7 No 4	Pregnant at time of Unknown	death 5 L	Other (specify)			Month	Day Year
P.O.	that th	by Ph	Part II. Other significant conditions contribut	ing to death but not res	sulting in the L	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	quires en sigr	ed b						1 □ Ye	s 2 No 3 No	Probably 4 X Unknown
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Re	t The licate h		25 W					perform	ned? death	Yes 2 No
/ita	siciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	ıl: 1 🔀 Inpatient 2 □	ER/Outnation	Othe	ace of Death (Chec		nce 6 🗆 Other (Sp	nerify)
of \	ng Phy ter this meral o		27. Manner of Death 1 🔀 Natural 5 🗌 Pending	a. Date of injury (Month, Day, Year)	28b. Time of injury		/ at	28d. Describe how		(SSI)
ion	tendir Jeath. Lor: Af the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 ☐ No			
Division	tal or Atres after of al Direct		4 ☐ Homicide determined 28	e. Place of Injury - At he building, etc. (Specif		eet, factory, office	9	28t. Location (Str. City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial-law.	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or 3 Certifying Nurse Practice.	the basis of examination	n and/or inves	tigation, in my opinic	on, death occurred a	t the time, date and	d place, and due to th	ne cause(s) and manner stated.
	within To #		29b. Signature and title of certifier	0		29c. License	number 06363		9d. Date signed (Mo	
			30. Name and address of person who complet							
			Pothu R. Nagabhuru, 31. Date filed (Month, Day, Year) FFR 08 2012	M.D., 150	Fore	st Glen R	oad, Sili	ver Spriv	ig, Maryli	and 20910
	Sta Registr		FFB 08 2012	The signal of th	7. 44	Com.				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Arthur Eugene Engman February 2012 0:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplac Country)
Ohio **Funeral** 9. Birthplace (State or Foreign 1 ★ M 2 □ F Days Hours 03/21/1929 228-26-6540 **Director** 82 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 44800 Medleys Neck Road 20650 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? . or Black, White, etc. 1 Never Married 2X Married b 1 ☐ Yes 2X No Specify. Specify: White If Yes Give "natural", 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permt. Page 1 and 2 should be filed with:
Department of Health and Mental Hygiens
Important: If item 27 is marked other the Manager Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Julius Engman Clara Kellv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean_Engman/Wife 44800 Medleys Neck Road, Leonardtown, MD 20650 ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Riverview Cemetery 02/18/2012 Waynesboro, VA 4 Donation 5 Other (Specify) Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home MO0052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death led by the a g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Completed 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 **X**No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death Funeral Director; A Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

8) Rome

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day Year) 16

DHMH 17 Rev 7/2009

Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical TEMER PRINST ERHART Scriptor CHESTER RYER MANOR CHESTER RYER RYER MANOR CHESTER RYER			4	For State	State of	Marylan		irtment of tificate of				00	112	05620
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Projection Pro				a. Facility Name (if not institution,	give street and numbe	er)		4b. City, Town,	or Location	on of Death			y of Death	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Ruth Volland Essex 2012 10:20 pM J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sanctuary at Holy Cross Burtonsville 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours **Director** 577-28-4729 1 🗆 M 2 🗶 F 90 Yrs May 14, 1921 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Tes 2 X No Burtonsville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3415 Greencastle Road 20866 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify "natural", Completed 3 X Widowed 4 Divorced White the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Louis Henry Volland Lula N. Wood injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any 649 S. Henderson Rd., #D612. King of Prussia, PA 19406 Rollie V. Essex - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Grdns. 02/06/2012 | Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee mellaucilianes 1232 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) e burial-transit requires that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year 5 Other (specify) Pregnant at time of death the g Unknown s been signed by the should be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Urinary Tract Infection 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Old Stroke cate has page 2 : autopsy performe death? 1 Yes 2 X No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending iniury X Natural 1 Yes 2 No Accident Investigation ipletely filled in by the 6 Could not be Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Month, Day, Year) FEB 06 2012 Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0054566

0/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2, 201 Artin Ervant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Regional Hospita Prince George's durel Laurel If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F April 08, 1921 Country) Ethiopia 90 216-31-2636 Director ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Beltsville Prince George's Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ethiopia 3017 Ellicott Road 20705 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Trade Merchant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Eid Ervant Der Ni Gogosian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 Mt. Eagle Drive, #1109, Alexandria, VA 22303 Philipos Artin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 02/07/2012 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} Acute Myocardial disease or condition Medical resulting in death) **Examiner** Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last burial ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Pain 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director. After this certificate I

Completed filled in by the funeral director, page 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description in Section 19 in S (Check 29d. Date signed (Month. Dav. Year) D0067662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency Dept. Perry R. Weisman, M.D. 7300 Van Dusen Road Laurel, MD 2070

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

FER 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 05632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9, 2012 4:25 Harry C. Edwards, Jr. РМ February Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Devlin Manor Health Care Center Cumberland, MD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2 □ F July 2, 217-28-6351 80 Maryland Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD LaVale Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 735 Valley View Dr. U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Je filed with. ✓al Hygiene. ✓er than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even ည Harry C. Edwards, Sr. Ethel Gabe (Palmer) Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 735 Valley View Dr., LaVale, MD 21502 Ruth Marie Edwards Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 13, 2012 Flintstone, MD Gap Vet. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hafer Funeral Service, tokn Hwy., LaVale, MD 1302 National 23a. Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betwe nset and D Immediate Cause (Final lancreas Caranoma Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam requires that the death certificate be executed physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Month Dav Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ (nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 N certificate 2 🗆 No 1 Tes **Division of Vital** • Hospital or Attending Physician: 24 hours af er death. • Funeral Director: After this certific eted filled ir by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 **S**(Vc ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
Feb, 10, 20/2 29c. License numbe

State Registrar

6+1 V

Sunil Gupta, M.D., 625 Kent Avenue, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)0033280

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar	_			Mental Hygi	ene				
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	<i>Death</i>	2. Date of Death	g. No. 2	12	05633		
H	Physicia		Robert Darrell	Eiland				Month	Day	Year	3. Time of Death		
ing	Medic Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, or	Location of Death	Februa	4c. County o		Clack H		
word	?		Meritus Medical	Center		Hagers	town		Washi		n		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	7.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			ace (State or Foreign		
	Director		225-68-1356 Usual Residence of Decedent	63	Yrs.			06/15/19	48	Virg	inia		
	land shov d at	호	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10	d. Inside City Limits		
	Mary 28a-f otifie	Director	Maryland Washingto	n I	lagerst	own					1 ☐ Yes 2X No		
	th the 3a or the n		10e. Street and Number		•	10f. Zip Code		10	g. Citizen of Wi	nat Count	γ?		
	ms 2	Funeral	10918 Coffman Ave.	Man Daniel Euroin III	0 140 14	21740			U.S.A.				
ယ	er deg or ite niner	by Fi	11. Marital Status 1 ☐ Never Married 2 X Married	. Was Decedent Ever in U.\$ Armed Forces? 1 X Yes 2 □ No		as Decedent of His Yes, specify Cubar	spanic Origin? (Span, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race Black	- America , White, et			
80	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	edk	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:	Whi	۱		
2-("2 hou "natu edica	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occupa ind of work done di	ation uring most of work	ina	6b. Kind of Bus				
121	ithin 7 ene. • than he M	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)		9	m 1 . t				
d 2	filed wall Hygi d other	Be	17. Father's Name (First, Middle, Last)		<u> </u>	k Driver	18. Mother's Nam	e (First, Middle, Mi		ng			
/lar	d be f Aenta arked tic ev	ပ္	Roy Eiland				Frances		,				
lan	should and Me is marl raumati		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	nd Number or Rura			te, Zip Co	de)		
≥	○ 主 る 主 に に に に に に に に に に に に に		Donna Eiland / Wi				Ave. Hag	gerstown,	Maryla	nd 2	1740		
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	noval from State	Place of Dispos cemetery, crem	ition (Name of atory or other place	e)	Date 2	0c. Location - C	ity or Tow	n, State		
턒	permit. Pa Departmer Important any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Smi	Lthsbur	g Cremato	ory 02/16	/2012 S	mithsbu	rg, l	Maryland		
Ba	Depar Impo any ir		> S. Munk Sui										
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of	ons that caused the deat	h. Do not enter	the mode of dying	, such as cardiac	or respiratory arres	t,		Approximate		
м,	Ph sician/		Immediate Cause (Final disease or condition	My	oca	rdia	ma	NECEZ	m	1	nterval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to ras a consequ	uence o	Too		and for	m, City or Town, State, Zip Code) 1. Maryland 21740 20c. Location - City or Town, State Smithsburg, Maryland Funeral Chapel erstown Maryland 21742 Approximate Interval Between				
		Je.	Sequentiary list conditions, b.	Leve	W	Joan	18pl	aur		N	10 Mus		
	ed	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (er as a consequ	uence of):	700	MOR	Witch	.0	1	MARC		
	xecut n and al-trar	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):	1	71/00	1		1	1000 63		
0	icate be executed physician and s the burial-transit	edical Examiner	d.	Har	rer i	cu &	son			10	tears		
Box 68760	tificat ng ph		IF FEMALE:	- ///						1/			
9 X	th cer ttendi or use	ian/		If yes, outgoine of pregna 1 Live Birth 2 Feta	al death 3 🗌	Ectopic pregnancy	/				1		
ß.	hat the death certificed by the attending detached for use as	Physician/M	1 Yes 2 No	4 ☐ Pregnant at time of c 9 ☐ Unknown	death 5 🗌	Other (specify)			Mont	h [lay Year		
P.O.	es that th signed by be detac	by Ph	Part II. Other significant conditions contri	buting to death but not les	ulting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contrib	ute to the	cause of death?		
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Division of Vital Records,	law require has been si je 2 should l	Completed		renary	- ar	1848	Msea	24a. Was an			y findings available		
Bec	sician: The la certificate ha irector, page 2	Com		an eith	1 6	2 /		autopsy perform	ed? de	or to com ath? Yes 2	pletion of cause of		
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	pital:			ce of Death (Check						
<u> </u>	nding Physician: 1 th. : After this certifica e funeral director, p	2	1 Yes 2 No	1 Inpatient 2 2	ER/Outpatient 28b. Time of		4 □ Nursing Ho	me 5 🗆 Residen		(Specify)			
o uc	ath. : Aftel	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c, Injury work? M 1 1		28d. Describe how	injury occurred				
ISIC	I or Attendi after death Director: A d in by the fi	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stree			28f. Location (Stre		or Rural R	oute Number,		
2	ital or Ins aft ral Dir lled in			building, etc. (Specify				City or Town,					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Greck 2 in Medical Examiner:	n: To the best of my knowl On the basis of examination	n and/or investig	ation. In my opinior	n death occurred at	the time date and	place and due to	the coule	e(s) and manner stated.		
	vithin or the	Σ	only one) 3 L Certifying Nurse P 29b. Signature and title of certifier	ractioner: To the best of my	knowledge, de	eath occurred at the	time, date and plac	e, and due to the ca	ause(s) and mann	er as state	ed.		
	F > F 0		& look	9W 1	W	20	04508	7 - 1	Date signed (I	VIOILIT, DE	8/7_		
			30. Name and address of person who comp	leted cause of death (Item	23a) (Type, Pr	nt)	1 F	11	20 11	11.	1422		
			SHAHAB 28	DETALL S	324	EU81 C	eureta	W 87	cel -	HAE	7111/21740		
	Stat Registra		31. Date filed (Month, Day, Year) FEB 2 7 2012	32 legistrar's Signat	1. pa	Mal					ψ*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05634 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ Elizabeth Eaton Viola 10:45P M Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 218-09-6109 92 **Director** 1 🗆 M 2XXF 4/9/1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director 28a-f 1 🗆 Yes 2 😾 💥 PA York Delta 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 2496 Bryansville Rd. 17314 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specifywhite 1 Yes 2XXNo Specify. Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Bank teller Banking permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Knoerlein Viola Captain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Eaton - son 2496 Bryansville Rd., Delta, PA 17314 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Cremation 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X X remation 3 Removal from State 2/16/2012 Leola,PA 4 Donation 5 Other (Specify) 21. Signature of Furier / Service to nse 22. Name and Address of Facility Koven Harkins F.H.Inc.,600 Main St.,Delta,PA 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Gerebrovascular accident Onset and Death Ph_sician/ 48 hours disease or condition resulting in death) Medical Due to (or as a consequence of) 8 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter d be detached for u in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? Yes 2 Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: e Hospital or Attending P 124 hours after death. e Funeral Director: After the 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide aton determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 02/15/2012 DOO 21207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franz C. Vella - Camilleri m.D. 5 midcrest ct., Baltimore, MD 21286 tranz 31. Date filed (Month, Day, Year FEB 2 State Registrar

DHMH 17 Rev 06-2011

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V1610

Amend Item 27 per me, g925,03/27/2012dhb
State of Maryland / Department of Health and Mental Hygiene
State Amend Items 2,25,28a-f,18 per dr./fh.g925,03/21/2012dhb
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State Amend Items 2,25,28a-f,18 per dr./fh.g925,03/21/2012dhb
Reg. No. 2 | | 2 2. Date of Death 02/04/2012 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2 Physician/ 2012 1:15 A^{M} Virginia Allen Freeman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 4601 Damascus Road Gaithersburg If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Tennessee 1 □ M 2X□ F Months Days Hours Min. Month, Day, Yea 1-4-1926 **Director** 86 404-28-1505 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō Funeral items 23a 20882 United States 4601 Damascus Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Secretary Be Page 1 and 2 should be filed went of Health and Mental Hygent; if item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mary Mabel Allen Ramsey Wert Allen 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) In Law 4601 Damascus Road, Gaithersburg Maryland 20882 Michelle Freeman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any Injury or ot 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2-7-2012 Tusculum Farm Gaithersburg, Maryland 21. Signature Funeral Service Lissee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg #M0910 Rockville, Maryland 20852 1170 Rockville Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 Hours Immediate Cause (Final Physician Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Stroke 15 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner APPROVED BY MEDICAL CHAMMER Due to (or as a consequence of) attending physician and for use as the burial-transit The law equires that the death certificate be executed 15 Years Head Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIFICATION P.O. Box 68760 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant
Unknown Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown een signed by the nould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed?
Yes 2 X No After this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: ^{28c.} Injury a**Unknown** 28d. Describe how injury occurred 1 Natural injury 5 Pendina Motor vehicle Accident July 1998 death. 1 Yes 2 No 2 X Accident Unknown/ Investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Sompleted filled in by determined City or Town, State) Unknown Unknown Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) C MD KJV كسه D0014507 2-4-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Gerwin MD, 7380 Old Georgetown Road, Bethesda Maryland 20814 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 9 2012 Registrar

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4		 Registrar Decedent's Name (First, Middle, Las 	st)			mouto or i	J G G G G G G G G G G G G G G G G G G G	2. Date of De			i i-na	3. Time of Death
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Funeral Director			□ M 2 X F	66		Months Days	Hours Mir	n. (Month, Da	ay, Year)		Country)
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or 28		10e. Street and Number		ROCK	VIIIC	10f. Zip Code			10g. C	itizen of Wha	at Country	/?
with t	eral	4214 Independence	Street			208	53		Uni	ted St	ates	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 ↑ Never Married 2 Married	12. Was Decedent 9 Armed Forces? 1 Yes 2		If	Yes, specify Cub	an, Mexican, Pue			,	White, etc	
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buriance.	edical	(Check 2 Medical Exam	rsician: To the best of niner: On the basis of e se Practitioner: To the	examination an	id/or investi	gation, in my opini	on, death occurred	d at the time, date	and plac	e, and due to	the cause	
To the rough	Σ	only one) 3 A Certifying Nur 29b. Signature and title of certifier	so rectitioner: 10 th	e best of My K	nowledge,	29c. Licens		piace, and due to		ate signed (N		
4		•				6223	4		Fel	oruary	8,	2012

Registrar

State

Nicholas Farrell, 9707 Medical Center Drive #300, Rockville, Maryland

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 7, 2012 Brian L. Francois 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Trinidad & **Director** 578-80-4789 1XX M 2 - F 54 Sept. 23, 1957 Tobago Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Takoma Park 1 Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 20912 USA 6701 Allegheny Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: "natural", Completed Specify. 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Apartment Complex Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ္ Evans Francois Enid Pemberton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Christobel N. Francois/Wife 6701 Allegheny Avenue, Takoma Park, MD 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Feb. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service U cen-Francing Address Coritins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injur that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 nding phys IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 28b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has b autopsy death? 1 Yes 2 🗌 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury work? 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

Completely filled in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Kanwaljit Nagi, MD

FEB 09 20

31. Date filed (Month, Day, Year)

20056063

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anna Mae Fenwick Feb 14 2012 5:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 48513 Beachville Road Inigoes Mary's 8. Date of Birth (Month, Day, Year) 1 / 28 / 1927 Birthplace (State or Foreign Country) Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 St F 85 MD **Director** 213 36 7770 Usual Residence of Decedent fshow th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's 1X Yes 2 ☐ No St Inigoes 10e. Street and Number 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 20684 USA 48513 Beachville Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No
If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Private Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Juliette Samuel Shubrooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48513 Beachville Rd.St.Inigoes, MD 20684 Beverly L.Fenwick/Daughter Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St.Peter ClaverCEM 3/78777 St. Iniques 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, in any, leading to increalist cause. Enter Underlying Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 2 1 No Yes 1 Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D63150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARASIM IHAM V. I 22576 MacArthur Blvd. WARA 4) eme California, MD Registrar's Signatur State Registrar

Amended # 20b, 02/17/12, R.M.L., St. Mary's Co.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB U

4.9

30. Name and address of person who completed cause of death (Item 23a)

29b Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 28, 2012

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 23a.pt.1c.25,27,28a-f.per me,g934 12-6-12 sm

For MEND#1 per Phy State of Maryland 7 Department of Health and Mental Hygiene 2 1 2

State Amend#10A-10F AACO HEALTH DEPT. CMH Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 February Helen Mari Forstmann 9:10 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 490-14-7068 Director 1 🗆 M 2 🕱 F 93 8-27-1918 MO Usual Residence of Decedent 28a-f show Town or Location
St. Charles 10d. Inside City Limits aţ State 10c. City Director Missouri St. Charles Examiner must be notified 1 Yes 2x No Anne Arundel Allianolis ō 0e Street and Number 417 Jackson Street 10f. Zip Code **63301** 10g. Citizen of What Country? Funeral 23a 2741 Gingerview 21401 Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. ō ģ 1 Never Married 2 Married Yes 2X XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event *** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Interior Decorator Interior Decorating 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theresa A. Roeper Albinus J. Orf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Slaughter / Daughter 2741 Gingerview Lane, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 K Removal from State cemetery, crematory or other place) 2/4/2012 Peters Cemetery St. Charles, MO 4 Donation 5 Other (Specif) 21. Sig | ture of neral Sirvice Li 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Parl 1. Enter the disease, thr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Seps Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner hous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examin BY MED Cause (Disease or injury that initiated events resulting in death) Last Pubic Bone Fracture TIFICATION APPR burial-trai Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physicis P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 2 100 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury subject fell off of kitchen 5 Pending 1 ☐ Yes 2 🔀 No Accident fd: 1-30-12 unk Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) **2/41 Gingerview Ln.** 4 Homicide determined Daughter's Home Annapolis,MD. Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Month, Day, Year) FEB 06 2012 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of H			giene Reg. No. 20	12	05641
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Sylvia	Friedman				Februar	y 9, 201	2	3:05 A M
	Examin	er	4a. Facility Name (if not institution, give		r Cara	4b. City, Town, or Betheso		h	4c. County		
	Funcual		Springhouse of V	x 7 Age (In vrs. la:		If Under 1 Year	If Under 24 Hrs	8. Date of Birt			ace (State or Foreign
	Funeral Director		216-40-0641	□M 2 🖰 F 96		Months Days	Hours Min.	April I	8,1915		Y YORK
	d ow		Usual Residence of Decedent 10a. State 10b. County	do City	, Town or Lo	ation				1/	d. Inside City Limits
	arylan a-f sh iied a	Director			, lowil or Loc	Bethesd					1 ☑ Yes 2 ☐ No
	he Ma or 28a notif	Dire	Md. Montgome	ry		10f. Zip Code	.a		10g. Citizen of V	Vhat Count	
	with t	Funeral	5101 Ridgefie	1d Rd.		208	16		U	S.A.	
	death items ier mi	Fun	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race	e - America k, White, e	ın Indian,
36	after c	l by	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		☐ Yes 2 💢 No		, , , , , ,	Specify:		
8	atura cal E	Completed	15. Decedent's Ed	Year or Dates.	16a, Deced	lent's Usual Occupa	ation		16b. Kind of Bu		
215	n 72 h e. an "n Medi	ldu	(Specify only highest gra	de completed) College (1-4 or 5+)	(Give)	kind of work done o O NOT use retired)	luring most of wo	rking			
21	J withi			4	H	omemaker			Hom		
Maryland 21215-0036	ntal H ed ot	To Be	17. Father's Name (First, Middle, Last)	A 1 d			18. Mother's Na	me (First, Middle, Tillie	Maiden Surname Jaco	_	
Ž	ould but Me mark		Jacob 19a. Informant's Name/Relationship (Ty	Axelrod	19b Mailir	ng Address (Street a	and Number or Ri				ode)
Z	and 2 sh Health ar tem 27 is			r/Daughter		Strathmo					
ore,	of Hear of Hear fiter r othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	20b. Pi	lace of Dispo	sition (Name of natory or other plac	1	Date	20c. Location -		
ij	Page ment tant: I		4 Donation 5 Other (Specify	nemoval nom state		s Cremato		0-2012	Riverda	le, N	/d
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0091 5	Name and Address nambers F 801 Cleve	uneral I land Ave	Home & C	rematori rdale, M	um, I id. 20	P.A. 0737
	0		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the death	n. Do not ente	er the mode of dyin	g, such as cardia	or respiratory an	rest,		Approximate Interval Between
, where	Physician/		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death								
-	Medical Examiner		resulting in death)	Due to (or as a consequent by Late Effects	•	mahmal We	agular.	Acaidant	, "i		
	100	ner	Sequentially list conditions, arrany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Late Effects Due to for as a consequ		reprai va	iscular 1	Accident			
	uted Id ansit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events	c. Hypertension							
	be executed sician and burial-transi	a E	resulting in death) Last	Due to (or as a consequ	ience of):						
=		edical		d							
.89	certific nding use as	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		7			23d. Da	te of delive	ry
Box 6876	e atter	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐XNo	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Other (specify)	;y 		Мо	onth	Day Year
P.O.	t the o	Phy	g ☐ Unknown Part II. Other significant conditions co		ulting in the u	inderlying cause giv	en in Part I	22a Did t	phacco use cont	ribute to th	e cause of death?
о, С.	ires that the dea signed by the a Id be detached f	d by	Dementia			,					ably 4 🗆 Unknown
ord	require been si should I	lete	**************************************					24a. Was		Were autop	sy findings available
Sec.	sician: The law i certificate has b lirector, page 2 s	Completed						auto perfo	rmed?	prior to cor death? 1 □ Yes	npletion of cause of
a F	ian: T rtifica stor, p	Be	25. Was case referred to medical examiner?			26. PI	ace of Death (Che		ZALJINOJ		
<u> </u>	hysic his ce al dire	ျ	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2			4 L Nursing	Home 5 Resid		er (Specify)	SISTED LIVING
l of	ding P. J. After t funera	ate	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe f	now injury occurr	ed	
Division of Vital Records,	Atten	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho			100 2 2 110		Street and Number	er or Rural	Route Number,
Div	tal or rs afte al Dire ed in t		4 D Hornidae	building, etc. (Specify)) 			City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director, there this certificate has been signed by the attending phy To the Funeral Director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination to Practioner: To the best of my	and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	and place, and du	e to the cau	ise(s) and manner stated.
_	To t With Com		29b. Signature and title of certifier	ya,		29c. Licenso			29d. Date signed	d (Month, E	Day, Year)
	5		30. Name and address of person who d	ompleted cause of death (Item	23a) (Type 1		5579		الم الم	1/0	1010
	14		Susan J. Mille	er, M.D. 82	18 Wis	consin A	ve. Suit	e 305, B	ethesda	, Md.	20814
	Sta Registra		31, Date filed (Month, Day, Year) FEB 1 0 2012	32. Rehistrar's Jignat	les s						

DHMH 17 Rev 7/2009

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			State of Maryland		artment of H <i>tificate of D</i>			20	10	05610	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncale or L	reau i	2. Date of Deat	teg. No. 🗶 🔱	16	3. Time of Death	
	Physicia Medic		Olivia Figueroa			Month Day 01/26/2012		Year	2:30 p ^M		
	Examir		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County		y of Death	
	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last)				Takoma Park oirthday) If Under 1 Year If Under 24 Hrs.		8 Date of Birth		gomery 9. Birthplace (State or Foreign		
	Funeral Director		214-21-9626 _{1 \(\text{M} \) 2 \(\text{F} \) 71}	Yrs.	Months Days	Hours Min.	(Month, Day, 04/16/1	Year) 940	Count	ry)	
	id it	با	Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Loc	ration				1/	Od. Inside City Limits	
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	the N a or 28	Ϊ́	10e. Street and Number		10f. Zip Code			10g. Citizen of V		try?	
	th with ms 23 must	Funeral Director	1701 Mount Pisgah Ln		20903			Hondura	S 		
(0	er deat or iter niner	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No		Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		e - America k, White, e	tc.	
ğ	ural", ural", il Exar		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	1 型 Yes 2 □ No Specify: Hond			Specify:	Specify: Hispanic		
15-	72 hor n "nat Aedica	To Be Completed	(Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)		ing	16b. Kind of Bu	isiness/Ind	lustry	
21215-0036	within giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+)		ekeeper			Self E	mp1oy	ed	
nd	pe 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last) Tomas Figueroa			18. Mother's Nam)		
1		_		Bernanda Madrid g Address (Street and Number or Rural Route Number, City or Town, Sta				tota 7:= 0	a da)		
Baltimore, Maryland	d 2 sh alth ar n 27 is er trau		19a. Informant's Name/Relationship (Type, Print) Maria Luisa Gonzales/Daughter 		Mount Pi						
ore,	ge 1 and the strong He He He He He He He He He He He He He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Pla	ce of Dispos netery, crem	sition (Name of natory or other place	o) i		20c. Location -	City or To	wn, State	
<u>ti</u>	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specify) Gene		Cemetery		03/2012	Hondu		0005	
Ba	Depa Impo any i		21. Signature of Fundal Service Limitine							. Home 3005	
		Examiner	23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death disease or condition								
F	h, sician/										
	Medical Examiner		resulting in death) Due to (or as a consequence of):								
	±A		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):	of):			OTIGO			
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8760	tificate ng phy as the	Medi	IF FEMALE:					1			
9 X	ith cert ttendir for use	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnand 1 Live Birth 2 Fetal of	eath 3		у	23d. Date Mont		ate of delivery onth Day Year		
Division of Vital Records, P.O. Box 68	he dea y the a	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea g ☐ Unknown	atn 5 L	Other (specify)						
P.0	s that t gned b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
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n of	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certificate:	27. Manne of Death 1 Hatural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Describe how injury occurred 1 Houstigation 1 Pending 1 Describe how injury occurred								
Sio		ərtific	3 Suicide 6 Could not be 28e. Place of Injury - At hom-	et, factory, office 28f. Location			(Street and Number or Rural Route Number,				
2			building, etc. (Specify) City or Town, State)								
	e Hosp 24 ho e Fune letely f	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Withir To the Comp	2	29b. Signature and title of certifier 29c. License number, 29d. Date signed (Month, Day, Year)								
	•	5619+ 1/26/12								2	
			30. Name and address of person who completed cause of death (Item 2: Kan Go M.D. 7600 Carro		*	a Dark M	M 2001		1		
	Sta	е	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	A P	. ISKOIK	A LULK P.	m. 20112	· · · · · · · · · · · · · · · · · · ·			
	Registra	ır	JAN 3 0 2012 June 1	. 196	Land .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FANGMEYER, SR. 20/2 LEROY JOSEPH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR MONTGOMERY MEDICAL OLNE MONTGOMER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Feb. 10 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days Min. 1 X M 2 | F 579-20-7908 85 Director Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 4301 Crossway Court 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. WWII other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Loretta Schlarman Albert Fangmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Lee J. Fangmeyer/Son P.O. Box 429, Ridge, MD 20680 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Jan. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2012 21. Signature of Funeral Service Licensee

Francis Source of Funeral 1 500 University Blvd. W., Si.

23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Francis Address Collins Funeral Home Inc. any 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final a ATHEROSCLEROTIC CARDIO VASCULAR set and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a our sequer ce of): sician and requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Month Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 4 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 204 00060319 no 1,26,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DARCIE

Registrar's Signati

HAMMER

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10101 PRINCE PHILIP DRIVE, OLNEY MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#24bperMD, 2/6/12; BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN EDWARD FREEMAN P^{M} JAN 30 201 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BETHESDA MONTGOMERY WRNMMC If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) Apr 13, Hours 1 X M 2 D F Min T958 Kansas Director 53 513-60-3947 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Montgomery Kensington Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9812 Hillridge Dr. 20895 United States of Health and Mental Hygiene.
item 27 is marked other than "natural", or items
other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) US Navy Dentist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Tokie Ono Edward Lyle Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9812 Hillridge Dr., Kensington MD 20895 Alison D Freeman/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Arlington National Arlington, VA Donation 5 Other (Specify) MAR 19, 2012 21. Signature of Funeral Services icensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. MD00956 Gaithersburg MD 20877 Park Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ SEPTIC SHOCK resulting in death) Medical Due to (or as a consequence of) **Examiner** DIFFUSE LARGE 5-CELL LYMPHOMA Sequentially list conditions Due to (or as a nonsequence of): cause. Enter Underlying in.
After this certificate has been signed by the attending physician and
After this certificate has been signed by the attending physician and
structure function, page 2 should be detached for use as the burial-trapsit Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 🟋 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 X Yes Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 🗓 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Knpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

MATTHEW C. ABOUDARA,

31. Date filed (Month, Day, Year)

01062622A

WRNMMC, BETHESDA, MD

20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#290penMD, 2/7/12; EMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death BENIAMINO Physician/ 2:27 PM FLERI February 2012 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Shock Trauma Center- University Many land Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Director 217-44-6359 1 X M 2 □ F 10/30/1930 Italy Usual Residence of Deceden shov 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 28a-f 1 X Yes 2 □ No Huattsville Maruland Prince George's 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 20782 5906 Chillumgate Road Italy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black White etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Caucasian 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shoesmith Retail of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Santa Santoro Antonino Fleri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is 7 or other train Maria D. Gardella - Daughter 7609 Charlton Ave.. Berwyn Heights. Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 02/06/2012 Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinal Vi Fine al Home, Inc. Solver spring, MD 20904 11800 New Hampshire Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last burialed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🗆 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? ☐ Natural Accident 2012 ear, Un Known M 5 Pending 1 🗌 Yes after death Director: A Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factor building etg (2007) The street, factor building etg (2007) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Marse Propertioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 , MD 100983 -at hame and address of person who completed cause of death (Item 23a) (Type, Print 4ni Aydun 21201 State Registrar

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		For State	State of M	1arylan		artment of H		Mental Hy	giene	001	0 05616
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permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland pearmit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation		e C	emetery, crer	matory or other place Peace		Date 7/2012		ation - City o	
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permi Depa Impo any ir		Michael	Jardine V			2. Name and Addre Mattingle 41590 Fen	y-Gardin wick St.	er Fune , Leona	ral H rdtow	ome, P n, MD	20650
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To th withir To th comp	2	29b. Signature and title of confiden	r	"		29c. License	e number		29d. Date	signed (Mont	th, Day, Year)
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3) eme		30. Name and address of person TACA 31. Date filed (Month, Day, Year)	who completed cause of o	death (Item	23a) (Type, F	Print)	# 207 1	islds	P M	206	03
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 6 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner innapolis v 5. Social Security Number N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth **Funeral** (Month, Day, 1 M 2 DF Months Hours Min ar) 012 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filen 27 is marked other than "natural", or it any injury or other traumatic event **-**. 10a. State 10b. County City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 🗓 ME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2,409 SA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) N/A N/AN/A Be 17_Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Ru al Route Number, arent 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 X Cremation 3 Removal from State 2/7/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition mona Medical resulting in death) Due to (or as a consequence of) Examiner 0 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death the page 2 should be detached Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director: After this certificate has be performed' 2 X No Yes 2 No 1 Yes Division of Vital Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 2 X No ျှ 1 🗌 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1. Natural 1 Yes 2 Nn Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Iter State Registrar

	For State Registrar	State of Maryland	-	tificate of L				. No. 🤈 (110	05	c I. o
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	Katrina D. Garrett		-		ns High	nway, A	pt. B	, Mil	lers	ville,	MD
ľ	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from State cer	metery, crem	sition (Name of atory or other place		Date				Town, State	
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	resulting in death)	Due to (or as a conseque	ence of):								
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	25. Was case referred to medical examiner?			26. P	ace of Death (0		Yes 2 2	& NO	1 L Yes	2 🗆 No	
	1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpatient 2 ☐ E		t 3 🗆 DOA Oth	er: 4 🛭 Nursir	ng Home 5	Residenc	e 6 🗆 Otl	her (Speci	ify)	
ľ	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	(Month, Day, Year)	28b. Time of injury	28c. Injur work			scribe how i	njury occur	rred		
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		se Practioner: To the best of my l	knowledge, d	eath occurred at th	e time, date and	d place, and d	ue to the cau	use(s) and n	nanner as	stated. , Day, Year)	
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) WI	X/NO.						100		U 9 4U	
	30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type, P	rint)	23207.	-					
	30. Name and address of person who con Njdeka Udochi, 905 31. Date filed (Month, Day, Year)		rive,	-			City,	MD 21	1042		
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Registrar

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in	Physicia Medic		1. Decognit's Name (First, Middle, Last) GRIFFIN	2. Date of Death Month Day & Year ADVIORY & 2012 2016 PM
-	Examin	ier	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. Country of Death 4c. Country of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Days Hours Min. (Month Day Year) Country
	Director		248 44 4837 1 St M 2 L F 78 Usual Residence of Decedent	01/29/1934 South Carolin
	yland •f shov ed at	ctor		y, Town or Location 10d. Inside City Limits estertown 1 □ Yes 2X No
	ne Mar or 28a- notifi	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	s 23a o	Funeral	212 Kennedy Drive	21620 USA
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
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Maryland	should be file and Mental t is marked o aumatic eve	-	Butler G 19a. Informant's Name/Relationship (Type, Print)	Griffin T.TIVTNTA Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 shoul Health and I tem 27 is ma		Mae Wyndham/Sister	212 Kennedy DR Chestertown, MD 21620
Baltimore,	permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau		1 V Burial 2 Cremation 3 Removal from State Cer	Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place)
Itim	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Holliness 2/16/2012 Butler, New Jersey 22. Name and Address of Facility Bennie Smith Funeral Home
Ba	permit Depar Impor any ir once.	- 2		855 High ST Chestertown, MD 21620
Specific	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque	an Arey Dislose Interval Between Onset and Death
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ls, P.O.	uires that the n signed by t ild be detach		Part II. Other significant conditions contributing to death but not result Hypulension	aulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records,	The law require cate has been s page 2 should	Completed by	Hyperlepedem on	24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No
of Vital	nysician: The nis certificate director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 Fig. 1	26. Place of Death (Check only one) Other:
of V	g Physer this	te: To	27. Manner of Death 28a. Date of injury 2	ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home St Residence 6 □ Other (Specify) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred
ion	tending leath. tor: After the funer	Certificate;	2 Accident Investigation	M 1 Yes 2 No
Division	I or Attendi after death. Director: A d in by the fu		4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examiner: On the basis of examination	ledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. n and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. y knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the sound of th	_	29b. Signature and title of certifier Valleil Gwaln	D.O. #0057921 29d. Date signed (Month, Day Year) 62/08/2012
	ms +		30. Name and address of person who condleted cause of death (Item 2 VAICHE GOOD MAN, D. 6	23a) (Type, Print) 2540 Centrente 12d O. Centrente 1 MD 21617
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 <u>5:4</u>5 P^M FEBRUARY THERESA CARMITA GRIFFIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **KENT** CHESTERTON NURSING AND REHAB CHESTERTOWN . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 XF Hours Min (Month, Day Year) 03/12/1918 93 Yrs. MARYLAND Director 206-20-8670 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MARYLAND KENT CHESTERTOWN 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 450 MORGNEC ROAD UNITED STATES 21620 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ö þ 1 Never Married 2 Married 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify. "natural" 3 XWidowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical [16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) q HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other. pe HARRY JAMES RUTH HOPKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH GRAHAM / GREAT NIECE 23 S. SIXTH STREET DARBY, PENNSYLVANIA 19023 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 02/15/2012 STEVENSVILLE, MARYLAND Signature of Funeral Service Licensee 22, Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Man 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Pat 1. Enter the disease, or complications that caused spock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final aselmatic - Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). requires that the death certificate be executed and -tran Due to (or as a consequence of) the burial ettending physician or use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ed by the 9 Unknown 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page Hospital or Attending Physician: The certificate 2 No 1 Tes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hour To the Fune completed file Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 11-1 Mlum, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Ave, Chestertown, MD 21620 KINK, WUN RM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1

Registrar

		Pleas	se Type or P					-	_	ible.	
	٠	For State Registrar		Marylan		artment of t tificate of t		l Mental Hy	giene Reg. No. 20	12 05651	
Physicia Medic		Decedent's Name (First, Middle, I TOSHIE ISHIKAW,	,					2. Date of De Month JAN	Day	3. Time of Death 2012 1:35 P ^M	
Examin	er	4a. Facility Name (if not institution, g		7)			r Location of Dea		4c. County	of Death	
Funeral Director				Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th	g. Birthplace (State or Foreign Country) Hawaii	
/land f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	eation				10d. Inside City Limits	
the Mar a or 28a- be notifie	Funeral Director	Virginia Fair 10e. Street and Number	fax	Sp	ringfi	eld 10f. Zip Code			10g. Citizen of \	1 ☐ Yes 2 🕵 No What Country?	
eath with tems 23a er must	Funera	6900 Highland St	12. Was Deceden		i. 13, W		22150 lispanic Origin? (\$	Specify Yes or No- rto Rican, etc.)	USA or No- 14. Race - American Indian,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	X No		Yes, specify Cuba		rto Rican, etc.)	Black, White, Specify: Japa		
iin 72 hou e. nan "natu e Medica	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12)	s Education grade completed) College (1-4 o	r 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retired)	during most of we	orking	16b. Kind of Bi	usiness Industry	
filed with al Hygien d other tl went, the	Be	17. Father's Name (First, Middle, Las	1	,	Hom	emaker	18. Mother's Na	ame (First, Middle,	Own Maiden Surname		
d Menta marked matic e	욘	Tomoichi Ishikav			T		Kuni Ha				
nd 2 sh ealth ar m 27 is ner trau		Jay C. Groff, Jr		nd	1			Rural Route Numbe			
Page 1 a nent of H int; If ite ry or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Conation 5 □ Other (Special Control of the Control	Removal from Sta	te ce	emetery, crem	sition (Name of atory or other place Cremator		Date 28 / 2012		City or Town, State	
permit. Departn Importa any inju		21. Signature of Funeral Service Lic		1100	22.	Name and Addre	ss of FacilityDe	maine Fur Springf	neral Ho	me	
		23a. Part 1. Enter incolsease, or co shock, or heart failure. List onl	omplications that caus y one cause on each li	ed the death ine,						Approximate Interval Between Onset and Death	
Physician/ Medical Examiner	9 1	disease or condition resulting in death)		ACEREB s a consequ		MORRHAGE	<u> </u>			Onset and Death	
n #^-	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ	ence of):						
executed ian and irial-transit	ᄪᅵ	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ence of):						
ficate be g physic as the bu	/edica		d								
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial completed filled in by the funeral director, page 2 should be detached for use as the burial director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 □ Fetal tat time of d	death 3	Ectopic pregnand Other (specify)	с у		23d. Dat Mo	e of delivery nth Day Year	
ires that the signed by	۾	Part II. Other significant conditions	s contributing to death	but not resu	ılting in the ur	derlying cause giv	ven in Part I.		_	ibute to the cause of death? 3 □ Probably 4 □ Unknown	
The law requate has been page 2 shoul	Completed							24a. Was	an 24b. V	Vere autopsy findings available prior to completion of cause of leath? Yes 2 No	
sician: certific irector,	8 B	25. Was case referred to medical examiner? 1 ☐ Yes 2 [X] No	Hospital:			Oth	ace of Death (Che	eck only one)			
iing Phy .r After this funeral d	ate: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of in (Month, D	jury	ER/Outpatient 28b. Time of injury	28c. Injury	4 ∐ Nursing y at ∵?	Home 5 Resid	ow injury occurre		
I or Attend after deat Director: d in by the	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	t be 28e. Place of Ir	njury - At hor etc. (Specify)	me, farm, stree	M 1 ⊔ et, factory, office	Yes 2 □ No	28f. Location (S City or Tow		r or Rural Route Number,	
ne Hospita n 24 hours ne Funeral	Medical	(Check 2 L Medical Exa	hysician: To the best o iminer: On the basis of urse Practioner: To th	examination	and/or investig	gation, in my opinic	on, death occurred	at the time, date a	nd place, and due	to the cause(s) and manner stated.	
To the within		29b. Signature and title of certifier Raicy R			- 7	29c. License			29d. Date signed	(Month, Day, Year)	

State Registrar Draig R. J. sursevortle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

CRAIG R. AINSWORTH, 31. Date filed (Month, Day, Year)

JAN 3 0 2012

DHMH 17 Rev 7/2009

061688

WRNMMC, BETHESDA, MD 20889 5600

January 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Registrar				Cer	incate of L	Jeani -		Reg. No 🛴 💟	l fram	00000
	Physicia		1. Decedent's Name The	e (First, Middle, La lma Hum	*	nn		-			2. Date of Death Month Day Year 2/4/2012 3. Time of Death 1006		
	Medic Examin				e street and number)			4b. City, Town, or	Location of Death		4c. County	of Death	1 TONO D
		М	18301 Ge 5. Social Security No	orgia Ave	= #323 ,	" .	t hat t	Olney		10 B : 15	Montg		
	Funeral Director		240-58-	2015 1	Sex 7. Ag	91	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Date) 9/25/19	(Year)	Coun	place (State or Foreign try) Carolina
	and show at	٥	Usual Residence of 10a. State	Decedent 10b. County		10c. City, T	own or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f s atified	Director	Md.	Montgome	ery	Olne	y						1 🗆 Yes 2 🖵 No
	th the	a D	10e. Street and Nun	nber		-		10f. Zip Code	_		10g. Citizen of \		ntry?
	ms 2; must	Funeral	18301 Geo:	rgia Ave	#323 12. Was Decedent	Ever in II C	10 14	2083		poify Voe or No-	U.S.	A e - Americ	a Indian
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ρ		ed 2 Married	Armed Forces? 1 Yes 2 X If Yes, Give			Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Blac	Black	etc.
9	hours natura iical E	lete		15. Decedent's E		1	16a. Deced	ent's Usual Occup	ation		16b. Kind of Bi	usiness Ind	dustry
21215	iled within 72 Il Hygiene. other than "r vent, the Med	Completed	(Spe Elementary/Seco	cify only highest gr	College (1-4 or a	5+)	(Give k life. DC	NOT use retired)	during most of worl cher	king	Educa	tion	
land	l be filed v lental Hyg rked othe	To Be	17. Father's Name (I Euger	First, Middle, Last)		-			18. Mother's Nan	ne (First, Middle, Sie Clay		e)	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na Jaoque 1		Type, Print) Tye- daugh:				and Number or Rui e Rd.,Bro	ral Route Numbe	r, City or Town, S		Code)
ore,			20a. Method of Disp		☐ Removal from State		e of Dispos	sition (Name of atory or other place	ce)	Date	20c. Location -	- City or To	own, State
ţi	t. Page tment o tant: If ijury or		4 Donation	5 Other (Spec	ify)	Ardei		ematory	2/6/2		Hanover		
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Fur	neral Service Licen 1 Napper	1. C	Mo15		Name and Addres					
			23a. Part 1. Enter t	he disease, or con	nplications that cause one cause on each lin	d the death. E						Approximate Interval Between	
- vide	Ph, sician/		Immediate Cause (disease or condition	Final		ESTIV	ت	HEART	FAILUR	E		776	Onset and Death
-	Medical Examiner		resulting in death)	ſ	Due to (or as	a consequen	ice of):	5511					ı
_	p T	miner	Sequentially list co it try cause. Enter Under Cause (Disease or	nditions, me of the dying	b. Due to (or as	a conse uen	nce of t					- 4	 -
	certificate be executed anding physician and use as the burialtrassit	n/Medical Examiner	that initiated events resulting in death) I	s i	C. Due to (or as	a consequen	ice of):						
68760	cate b physics the b	edic	-		d								
P.O. Box 68	I law requires that the death certif has been signed by the attending je 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3	Ectopic pregnand Other (specify)	cy			te of deliventh	ery Day Year
P.O.	that th	by Ph	Part II. Other signif	-	contributing to death I	out not resulti	ing in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cont	ribute to ti	ne cause of death?
ds,	quires en sigr uld be	ed b		AL FIBR	ILLATION					1 🗆	Yes 2 No	3 🗌 Pro	bably 4 🗆 Unknown
Division of Vital Records,	e law rec has bee je 2 sho	Completed	PAS	SPNEA						24a. Was autop	osy	Were auto prior to co death?	psy findings available mpletion of cause of
Ä	in: The ifficate or, pag		25. Was case referre	ed to medical	L			26. Pl	ace of Death (Chec	perfo	2. No	1 Yes	2 No
Vita	ysicia is cert direct	To Be	examiner? 1 \(\sum \) Yes 2	X No	Hospital:	ient 2 🗆 ER	R/Outpatien	Oth	Or!	lome 5 Resid	lence 6 🗆 Oth	er (Specify	·)
of	ing Ph vfter th uneral	ate:	27. Manner of Death	5 Pending	28a. Date of inju (Month, Da	ıry 28	3b. Time of injury	28c. Injur work	</th <th>28d. Describe h</th> <th>ow injury occurr</th> <th>ed</th> <th></th>	28d. Describe h	ow injury occurr	ed	
sior	Attend death ctor: A y the f	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	be 290 Place of Ini	urv - At home	e, farm, stre	M 1 □ et, factory, office	Yes 2 □ No	28f. Location (\$	Street and Numb	er or Rura	Route Number.
Divi	tal or / irs after al Dire		4 ☐ Homicide	determined	building, et	c. (Specify)			g	City or Tox	m, State)		
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Euneral Director, After this certificate has been signed by the atternate the Euneral Director, After this certificate has been signed by the funeral director, page 2 should be detached for	Medical	(Check 2	Certifying Phy Medical Exam Certifying Mu	ysician: To the best of ning; On the basis of a rectioner: To the	f my knowlede examination are best of my kr	ge, death o nd/or invest nowledge, d	ccured at the time gation, in my opinion eath occurred at the	e, date and place, a on, death occurred e time, date and pla	nd due to the ca at the time, date a ace, and due to th	use(s) and mann nd place, and du e cause(s) and m	er as state e to the ca anner as st	ed. use(s) and manner stated. ated.
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			30. Name and address 1810 9	/ I I	completed cause of chillip ariv		3a) (Type, P			Louis 200	32	1	
	Sta		31. Date filed (Mont	Prince P	37. Registr	ar's Signature		Ked.	****	- 5.00			
	Registra	ar		.5	" Ken	U A.	17						

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Ailen Geraldine Go	1	zalez Sta I- For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 0565								
Physician Medical Examine	1/	 Decedent's Name (First, Middle, 	_{Last)} Geraldine	G	onzale	z		2. Date of Do		3. Time of Death 2237 hrs	
		4a. Facility Name (if not institution, Johns Hopkins Bayview	-	r)		4b. City, Town Baltimore	, or Location of D		4c. County of	Death	
Funeral Director		220-85-4354	. Sex 7. A	age (In yrs. 2	last birthday) Yr		Year If Under 2 Days Hours			Birthplace (State or Foreigry D Country)	
ne Maryland or 28a-f show any fied at once,		Usual Residence of Decedent 10a. State 10b. County MD Balti	imore		, Town or Loca undalk					10d. Inside City Limits 1 Yes 2 X No	
h the Maryland 3a or 28a-f sh otified at once		10e. Street and Number 7537 Ives La	ane			10f. Zip Cod 21	1222		10g. Citizen of Wha		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Filmeral Director	⋧┞	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor	1 Yes	s? 2 🔀 No	1 X	es, specify Cul	ban, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	No- 14. Race - White, Specify: 16b. Kind of Busin	White	
5-0036 red within 72 hour tygiene. other than "uatu the Medical Exan	- Lubieter	Elementary/Secondary (0-12)	College (1-4 or				life. DO NOT use	e retired)	none	locomitationy	
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 127 is marked other than umaric event, the Medica	9	17. Father's Name (First, Middle, La Luis Sayago 19a. Informant's Name/Relationship	Vega	hor	19b Mailin	n Address (St	Yasmi	n Gonza	, Maiden Surname) alez Heri umber, City or Town,		
and 2 shou eaith and N rem 27 is n	Ĺ	Yasmin Gonza		ndez		Ives	Lane I	or Rural Route N	Marylan	d 21222 ity or Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other Special Signature of Funeral Service Lie	cify: 1	State P	crematory or ot anteon Santa	herplace) Princ Monica	cipal 2	2/10/201	Yecap:	ixtla, os,Mexico	
Balt Bermit Depart Import Import		23a. Part I. Enter the disease, or co	Mr	d the death	92	41 Co.	lumbia	Blvd.Si	ilver Sp	ring,Md20910	
/Medical Examiner		failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. a. Peritonitis Due to (or as a cons	sequence c	of):					Between Onset and Death	
200	֓֞֞֞֜֞֓֓֓֓֓֓֓֓֓֓֟֟֓֓֓֓֓֓֓֓֟֟֓֓֓֓֓֟֟֓֓֓֓֟֝֟֓֓֟֝֟֝֟֝֟֝֟֝֟֝֝֟֝	Sequentially list conditions, fany, leading to immediate	Due to (or as a cons		of):						
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate th within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buellical Certification: To Be Completed by Physician/Me	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unkno		it time of de	2 Fe	tal death Sher (Specify)	3 Ectopic pre	egnancy	23d. Date of de Month	Day Year	
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Division of Npital or Attending Phypital or Attending Phyous after death. reral Director: After if filled in by the funeral Certification: Tr		 17. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investig 	ation	Year)	28b. Time of I	1	njury at Work? Yes 2 No	-5.42	how injury occurred		
Division o Hospital or Attending 24 hours after death. Funeral Director: Afti recty filled in by the fune all Certification:		Suicide 6 Could n 4 Homicide Could n	ned (Specify)		ome, farm, stree			or Town,	State)	or Rural Route Number, City	
To the Hospital within 24 hours a completely filled	0	Check only 2 Medical Examin	iclan: To the best of n ner:On the basis of exa and manner stated			ion, in my opini	on, death occurr		e and place, and due	to the cause(s)	
3 3		9b. Signature and title of certifier Carde,	Haller				nse number		January 22, 2	(Month, Day, Year)	
			tant Me dical Exa	miner 9	900 W. Balt	imore Stree	et, Baltimore,	MD 21223			
State Registra	3	1. Date filed (Month, Day, Year) FEB 0 0 20	3. Registra	ar's Signa u	re part						

OCME

		For State	State of Ma	aryland /		artment of F tificate of D		viental Hy		0010	OFEF		
		Registrar 1. Decedent's Name (First, Middle, I	Last)		Cel	uncate or L	- Jeaur	2. Date of De	Reg. No	0.61116	3. Time of Death		
Physicia		Carolyn D.	Green					Month 01	Da 3	1 2012	12:25 a _M		
Medic Examin		4a. Facility Name (if not institution, g				4b. City, Town, or	Location of Death	01		County of Deat			
		Holy Cross Hos	pital			Silver	Spring			Montgome	erv		
Funeral				(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av. Year)	9. Birt	hplace (State or Foreign		
Director		577-70-9106 Usual Residence of Decedent	12 11 2 2 1	52	Yrs.			07/19/	1959) Was	hington, DC		
show show	or	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits		
illed within f2 hours after death with the Maryland all Hygiene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at	Director	MD Prince	Georges	Cani	ital	Heights					1 🏝 Yes 2 🗌 No		
the f	Ξ	10e. Street and Number	ucorges i	oup.	LCUI	10f. Zip Code			10g. Ci	tizen of What Co	untry?		
n with	Funeral I	506 Quarry Ave	nue			2074	3			USA			
deatl	ı Fu	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White			
after al", ol xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🔀 Divorced	If Yes, Give	No	1	☐ Yes 2 🔀 No	Specify:						
nours vatura ical E	lete	15. Decedent		16	Sa. Deced	ent's Usual Occupa	ation		16b. K	Lack Industry			
e. nan "r	Completed	(Specify only highest Elementary/Seconday (0-12)	t grade completed) College (1-4 or 5	+)	(Give k life. DC	aind of work done d NOT use retired)	luring most of work	ing		,			
ygien her ti rt, the	Be C		2		Mana	ger Tech	nical Ser	vices	es Private				
Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.	To B	17. Father's Name (First, Middle, Las	_				18. Mother's Nam	e (First, Middle	, Maiden	Surname)			
mark mark		Thomas Gordo		1	Adelaide Paige King								
th and thange 27 is a traur		19a. Informant's Name/Relationship			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3140 Apple Road, NE Washington, DC 20018								
Heal tem (Tiffany Green 20a. Method of Disposition	- Daughter			sition (Name of		Date		ocation - City or			
nt: If i		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe				natory or other place 1n Crema	e)			,			
oartm Sortai / injui		21. Signature of Funeral Service Lic						1.inco		rentwood uneral H	lome, Inc.		
		Day Montage		Clan	> 34	01 Blade	nsburg Ro	ad Br	entw		yland 20722		
		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that caused ly one cause on each line	the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between		
hysician/		Immediate Cause (Final disease or condition	_ a _ Cardiac		s.t						Onset and Death		
Medical xaminer		Due to (or as a consequence of):											
	er	Sequentially list conditions, if any, leading to immediate b. Severe Pulmonary Hypertension Due to (or as a consequence of):											
ısıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury			,	: Failure							
al-transit	Еха	that initiated events resulting in death) Last	c. Kigit a Due to (or as a			. Fallule							
rsician e buria	ical		d.							İ			
g phy as the	Med	IC CEMALE.	_ u										
attending physician for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		ath 3	Ectopic pregnanc	·V			23d. Date of del	ivery		
ed for	sici	in the past 12 months? 1 ☐ Yes 2 점 No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unk <i>n</i> own			Other (specify)	1			Month	Day Year		
by the	Phy	Part II. Other significant condition	s contributing to death b	it not resulting	n in the u	nderlying cause giv	ren in Part I	220 Did	tobassa	uca contributa to	the cause of death?		
- to	d by	Trait ii. Other digrimoditi condition	s contributing to death by	at not rooditing	g iii tiio tii	ndonying caddo giv	of mirror.				robably 4 Unknown		
signed be det	Completed										topsy findings available		
peen signed l	ldm							24a. Was			completion of cause of		
has been signed by the green second be detached	ပိ	25. Was case referred to medical				00 0		1X Yes	2 🔲 N		2 🗆 No		
ficate has been signed or, page 2 should be det	d)	examiner?	Unanitali		Outnotion	Othe	er:		(5£.1		
s certificate has been signed lirector, page 2 should be det	o Be	1 Yes 2 No	Hospital:	☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						(TY)			
or this certificate has been signed leral director, page 2 should be det	To B		1 🔀 Inpatie 28a. Date of injur	y 28b	injury work?					d. Describe how injury occurred			
ath. r. After this certificate has been signed he funeral director, page 2 should be det	To B	1 ☐ Yes 2 🔀 No 27. Manner of Death 1 🔀 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investiga	1 🗵 Inpatie 28a. Date of injur (Month, Day)	y 28b		work	?	28d. Describe	now injur	y occurred			
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us after death. ral Director. After this certificate has been signed led in by the funeral director, page 2 should be det	Certificate: To B	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	1 ☑ Inpatie 28a. Date of injur (Month, Day. 28e. Place of Inju building, etc	y ; Year) 28b ry - At home, . (Specify)	injury farm, stre	M 1 □	? Yes 2□No	28f. Location (City or To	Street an wn, State	nd Number or Rur)			
24 hours after death. Funeral Director: After this certificate has been signed ited filled in by the funeral director, page 2 should be det	Certificate: To B	1	1 ☑ Inpatie 28a. Date of injur (Month, Day 28e. Place of Injur building, etc 2hysician: To the best of aminer: On the basis of examiner.	y Year) 28b ry - At home, . (Specify) my knowledge camination and	farm, stre	M 1 ☐ work 1 ☐ eet, factory, office cocured at the time, igation, in my opinion	? Yes 2 No date and place, alon, death occurred a	28f. Location (City or To	Street an wn, State ause(s) ar and place	nd Number or Rur	ted. cause(s) and manner state		
ithin 24 hours after death. • the Funeral Director. After this certificate has been signed in properties or properties of the funeral director, page 2 should be detended in the funeral director, page 2 should be detended.	To B	1	1 ☑ Inpatie 28a. Date of injur (Month, Day) at be ed 28e. Place of Injur building, etc	y Year) 28b ry - At home, . (Specify) my knowledge camination and	farm, stre	M 1 □ eet, factory, office accurred at the time, igation, in my opinic leath occurred at the	? Yes 2 No No date and place, and place and place and place and place.	28f. Location (City or To	Street an wn, State ause(s) an and place ne cause(nd Number or Rur) and manner as sta a, and due to the o s) and manner as	ted. :ause(s) and manner state stated.		
within 24 hours after death. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be determined.	Certificate: To B	1	1 ☑ Inpatie 28a. Date of injur (Month, Day 28e. Place of Injur building, etc 2hysician: To the best of aminer: On the basis of examiner.	y Year) 28b ry - At home, . (Specify) my knowledge camination and	farm, stre	M 1 work 1 iet, factory, office ccured at the time, igation, in my opinic leath occurred at the 29c. License	? Yes 2 No date and place, ar nn, death occurred a e time, date and pla	28f. Location (City or To	Street anwn, State ause(s) ar and place ne cause(nd Mumber or Run and manner as state, and due to the cost and manner as	ited. cause(s) and manner stated stated. a, Day, Year)		
ate has been signed	Certificate: To B	1	1 🗷 Inpatie 28a. Date of injur (Month, Day) 28e. Place of Inju building, etc Physician: To the best of aminer: On the basis of ex lurse Practioner: To the	y, Year) 28b rry - At home, (Specify) my knowledge tamination and best of my kno	injury farm, stre e, death c d/or invest wledge, d	work M 1 iet, factory, office accured at the time, igation, in my opinic leath occurred at the 29c. License	? Yes 2 No No date and place, and place and place and place and place.	28f. Location (City or To	Street an wn, State ause(s) an and place ne cause(nd Mumber or Run and manner as state, and due to the cost and manner as	ted. :ause(s) and manner state stated.		

State 31. Date filed (Month, Day, Year)
Registrar 550 9 2012

DHMH 17 Rev 7/2009

32. Registrar's Gignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Ma State Registrar	ryland / I	Department of Certificate of		ental Hygiene Reg. No. 2012 0565			
	Physicia	n/	Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	,		2. Date of Dea Month		Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and number)		Harris Harris	or Location of D	Placery		2012	1624 M
	Examin	er	The Johns Hopkins Hospin	ful	Baltin	work (? +2			
	Funeral Director		5. Social Security Number 161 − 28 − 3131 6. Sex 17. Age	(In yrs. last birt 77	thday) If Under 1 Yea Months Days Yrs.		Min. 78. Date of Birth (Month, Day) Oct. 21	Year)	Counti	ace (State or Foreign ry) nsylvania
	nd thow at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town			000. 21	, 1991		Od. Inside City Limits
;	Maryla 28a-f s otified	irect	Maryland Anne Arundel		An	napolis				1 ☐ Yes 2 🙀 No
:	s 23a or	Funeral Director	10e. Street and Number 2659 Ogleton Road		10f. Zip Code	21403		10g. Citizen of '	What Count .S.A.	ry?
9036	ould be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3XX Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 ☑ Yes 2 □ Norced 14 Yes Give Year or Dates.		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2★★	ban, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)		e - America ck, White, e Whit	tc.
15-(n "nati In "nati Medica	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occi (Give kind of work done life. DO NOT use retire	e during most of	f working	16b. Kind of B	usiness/Ind	ustry
212	Hygiene. Other tha ent, the N	Be Co	Elementary/Secondary (0-12) College (1-4 or 5+)	Archite	ect			hitec	ture
/land	should be filled and Mental Hy 7 is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last) (unknown)			18. Mother's	Name (First, Middle, M unknot)		e)	
	thar thar trau		19a. Informant's Name/Relationship (Type, Print) Kacy Goldsby/stepdaughter	19b	o. Mailing Address (Stree 032 Stone S	et and Number o	or Rural Route Number, Ourt Eure	City or Town, S Ka, Mis:	State, Zip Co Souri	ode) 63025
┺ .	ge 1 and it of Heal if item; or other		20a. Method of Disposition 1 ☐ Burial 2 ★★ remation 3 ☐ Removal from State	cemete	f Disposition (Name of ry, crematory or other pl		Date	20c. Location	-	
altin	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Balti	22. Name and Add		/8/2012 John M. Tay			Maryland Home
m	B B B B B B B B B B B B B B B B B B B		I todd E. dille	7	147 Duke o	of Gloud	cester St.	. Annap		
P	hysician/ Medical		23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	e		ring, such as car	rdiac or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	,	Sequentially list conditions.	P Val		~				
70	ansit	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury	consequence	vie repair of): Volve G	epair				
_	physician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a	consequence	of):					
3760		Medical	d.							
	requires that the death behinded to be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the post 12 months? 4 ☐ Pregnant at the pregnant at the post 12 months?	Fetal death	h 3 Ectopic pregna 5 Other (specify)				te of deliver	ry Day Year
O.	been signed by the should be detach	by Pr	Part II. Other significant conditions contributing to death but	t not resulting i	in the underlying cause	given in Part I.				e cause of death?
	been si	eted					1 ∐ Y			ably 4 Unknown
Records,	ite has law	Completed		-			autop:	med?		npletion of cause of
Ital	certifica rector, I	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		10	Place of Death ((Check only one)		Half Care to C	
Division of Vital	ter this	te: To	27. Mariner of Death 28a. Date of injury	28b. 7	Itpatient 3 LI DOA Time of 28c. Inji	4 ∟ Nursi	ing Home 5 Residence 28d. Describe ho			
Sion	death. ctor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No	28f. Location (St	reet and Numb	er or Rural I	Route Number
	irs after al Direction be		4 Homicide determined 256. Place of Injur- building, etc.		, m, otroot, lactory, office		City or Town		er Or Hurair	
100	to the proposal of weaking reported. The raw within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of model of the control of the control of the control of the control of the certifying Nurse Practitioner: To the	amination and/o	or investigation, in my opin	nion, death occur	rred at the time, date ar	d place, and du	e to the caus	se(s) and manner stated.
F	within To th	~	29b. Signature and title of certifier		29c Licer	se number	2	9d. Date signe	d (Month, D	
			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, Print)	1 4 13	3 le Baltimore	Chach	5/	2012
			Kek: R. Balsara - 60	O N.	Wolfe 5	Keet, E	Salpinore	MD	21.	287
	Stat Registra		31. Date filed (Month, Day, Year) S2. Registrar	a Signature	backet					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Day 0535 a M Physician/ 2012 <u>Theresa A. Hogue</u> Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Hagerstown Meritus Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Year) Months Director 1 □ M 2 🛣 F 198-16-5108 86 Yrs 05/22/1925 Meadville, Usual Residence of Deced 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No MD Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21742 19810 Spring Creek Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry id 2 should be filed within. (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+) the Zipper Manufacturing Production Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Rossi Piccoli Anna Theodore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 19810 Spring Creek Road, Hagerstown, James Hogue / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services, Inc. 02/16/2012 | Erie, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 13, 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RINAL Immediate Cause (Final CUTE PAILURG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TPEX > Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury DEMENTIA Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 13 MOHAMMED A212 2 12 D66892

Registrar

DHMH 17 Rev 06-2011

17

11116 Medical Campus Road, Hagerstown,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Dr. Mohammed Aziz

31. Date filed (Month, Day Yelr)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vivian Hargrove February 2012 12:09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington 8003 Neville Place If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Days Min 4/19/1 1 M 2 X **Director** 578 54 0834 81 NC Usual Residence of Decedent 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 800 Southern Ave. SE #429 72 hours after death with 20032 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Yes 2X No 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 XWidowed 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hours autment of Health and Mental Hygiene. sortant; If item 27 is marked other than "naturinjury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housekeeping Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Parker Emma White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8003 Neville Place Ft. Washington, MD 20744 Dorothy Debold/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant; If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 2/18/2012 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Sign to e of Funeral Service Licenses 2294 Old Washington Rd. Waldorf, MD20601 Part 1. Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe death? 2 🗌 No 1 Yes Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) remove examiner? Hospital Other: 2 X No မ 4 Nursing Home 5 Residence 6 Nother (Specify nouse 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) re Hospital or Attending Pl n 24 hours after death. re Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only o 29d. Date signed (Month, Day, Year) H Mode 12 WH ANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Suit 204 Oxon Hill, MD 20745 <u>Mahmood Mohamadi</u> 6130 Oxon Hill 31. Date filed (Month, Day, Registrar's Signature back Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 18:37 FM Ethyl Pauline Henion 2012 Februar Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Crofton 1719 Swinburne Avenue Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Hours 93 465-26-3845 Director 1 □ M 2 🗓 F Yrs. Apr. 29, 1918 Wyoming 10d Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County must be notified at Director 1 Yes 2 No Crofton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number o 23a Funeral 21114 U.S.A. 1719 Swinburne Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: er than "natural", c , the Medical Exam If Yes, Give Year or Dates Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elizabeth Bundy Clair Harlan Roberts other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other tran once. 1719 Swinburne Ave., Crofton, MD 21114 Patricia M. Touma/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
Signatur of Fun r Oakwood Cemetery 2-6-2012 Frederic, Michigan 22. me and Address of Facility Beall Funeral Home NW Crain Hwy, Bowie, Maryland 20715 6512 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tan Congestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) dweeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Atrial Fabrillation, Cerebro Completed by 2 No 3 Probably 4 Unknown 1 Yes vascular accident, osteoarthrotis, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1246992 2012 Musicocc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1438 Defense Hwy Egyptills Muscovida MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES HERBERT Jr. 2:19 PM Februar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Regional Hospita Prince George's Laure 7. Age (In yrs. last birthday) 7 9 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

AMS Ath, Day, 9'ear) 1 9 3 2 Sex 13CM/ 2□ F 9. Birthplace (State or Foreign **Funeral** Min Months Hours 577 3952 44 Newy Jersey Director Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Md Prince Georges Suitland 1 Yes 2 No 10e. Street and Number 6267 Maxwell Drive 10f. 200946 10g. Citizen of What Country? Funeral U.S. A. . Was Decedent Ever in U.S. Armed Forces? KOREAN 1 G Yes 2 No If Yes, Give 9 5 4 - 1 9 5 6 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black "natural", al Hygiene. I other than "nature vent, the Medical E Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Corrections Officer 1 College (1-4-or 5+) State Government other traumatic event, Be 17. Father's Name (First, Middle, Last)
Charles L. Herbert Sr. ¹⁸ Mother's Name (First, Middle, Maiden Surname) LaLa Virginia Lewis and Mental Fis marked o t. Page 1 and 2 should by thent of Health and Mertant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9590 Muirkirk Road, Laurel, Maryland 20708 Rodney Herbert, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State ō Department of Important: If any injury or once. 2/11/2012 Metropolitan Alexandria, Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hall Brothers Funeral Home 21. Signature of Funeral Service Licensee NW, Washington DC 2001 621 Florida Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** Empyema Sequentially list conditions, Due to (as a consequence of): if any, leading to immediate cause (Disease or iinjury that initiated events Exam Meumonia and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Cerebral Infarct Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Diabetes Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Hyperlipidemia performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Hypertension 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M February 2012 D50412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital Natesa Shanmugam, 7300 Van Dusen Road MD Laurel 31. Date filed (Month, Day, Year State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 9×200 519ce 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Months (Month, Day, Year) Director None. 1 M 2 X F 75 08/19/1936 Ghana 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Laurel Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20723 USA 8757 Boulder Ridge Road "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗶 No If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced Black Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Merchandise Trader Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Priscilla Parker Frank Anan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Arthur - Daughter 8757 Boulder Ridge Road, Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 02/25/2012 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician} disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last 6 Due to (or as a consequence by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Be Completed မ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-time. Division of Vital Records, P.O. Box 68760 Certificate: Medical

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the Maryland

permit. Page 1 and 2 should be filed within 72 hours after death with

other

Baltimore, Maryland 21215-0036

Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)
1 Yes 2 200	Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursin	g Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
20a Cartifiar 1 Cartifular Blue	pinion. To the best of my knowledge, death accurred at the time, date and place	and due to the source(a) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

000277

29d. Date signed (Month, Day, Year)

29c. License number

State Registrar (Check only one)

29b. Signature and title of certifie

30. Name and address of person who comp

Cedar Lane Columbia 31. Date filed (Month, Day, Year) Registrar's Signatu **JAN 3** 0 2012

ited cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2012 ам February Beverly Jane Hurst 6:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3333 University Blvd., Unit 1201 Kensington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) Days Director 285-30-7815 1 M 2 🗆 F 79 Jan. 16, 1933 Ohio 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 X No MD Montgomery Kensington ō 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 3333 University Blvd., Unit 1201 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc 5 ρ 1 Never Married 2 XMarried Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Divorced 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Equal Employment Specialist Army Corps of Engineers event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Alvin Scott Janice Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Chaverly Hurst Osborne/Daughtet 11409 Gunpowder Drive, Fort Washington, MD 20744 other Saltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Feb. 12, Department of Important: If any injury or injury or 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA permit. 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver MD 20901 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph_sician/ Peritonitis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ending physician and use as the burial liansit Cardiomyopathy Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ COPD, Obesity, Hypernatremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗆 No Yes 2 K No 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, P.O. Box 68760 sompletely filled in by the

Registrar

DHMH 17 Rev 06-2011

State

Medical

29a. Certifier

(Check

only one) 29b. Sig

31. Date filed (Month, Day, Year,

ature and title of certifier

07 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Connecticut Avenue, Kensington, MD 20895

62. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0060658

29d. Date signed (Month, Day, Year)

3

29c. License number

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Day Physician/ 1328 2/15/12 Gary Hunt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westernport Allegany 102 Roosevelt 8. Date of Birth (Month, Day, Year) January 10, 1955 9. Birthplace (State or Foreign Country) Michigan 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Months Min 216-66-0484 57 Director 1 XM 2 □ F Usual Residence of Decedent 28a-f show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Allegany Westernport Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Roosevelt Street 21562 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. T Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify White 3 Widowed 4X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Town 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Shirley Anges Beeman Harold Louis Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Linda Alexander - Girlfriend 51 Jones Street, Apt. 308, Piedmont, West Virginia, 26750 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State February 20. 1 X Burial 2 Cremation 3 Removal from State Lonaconing, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Complications of CVA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 🗌 Yes Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) To the Hospital or new within 24 hours after death.

To the Funeral Director. After this control of the funeral director and the funeral director. မ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D09157 2/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STIV W Snow-M. D. 124 3rd St Cumberland MD 21502 31. Date filed (Mont FEB 2 7 2012 State Registrar

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Box

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day O 11:00 p_M Physician/ February 2012 Edgar Fallin Insley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pines Genesis Elder Care Talbot Easton If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 212-18-6087 90 1 X M 2 🗆 F June 24, 1921 Maryland or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Bethlehem 1 Yes 2 X No Caroline 10f. Zip Code 10g. Citizen of What Country? Funeral 21609 USA 21966 Dover Bridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 N Black, White, etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give WWII "natural", 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumastic. doctors office janitor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aberta Abbott Thomas H. Insley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Halifax Ave., Stephens City, VA Charles M. Insley son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 2/15/12 Hurlock, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. ature of Funeral Service Licensee 700 Locust St., Cambridge, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ji.e. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dire to for as a consequence of and that initiated events ng physician ar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 signed by the attending p nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Urknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pendina work?
1 Yes 2 No Investigation Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ٥

Registrar

Please Type or Print in Black Indelible Ink. Eysurg/All Conjes Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 5 Physician/ Jonathan Jenkins 2012 9:40 am February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomeru 531 Randolph Road, #228A If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 **X** M 2 □ F **Director** 85 01/08/1927 Indiana 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location at Director notified 1 Yes 2 No Silver Spring Maruland Montgomeru 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be Funeral items 23a 20904 U.S.A. 531 Randolph Road. #228A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner rmed Forces Black. White, etc. ō þ 1 Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. 'natural", WWII Completed 3 Widowed 4 Divorced White. Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry Social Security life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Administration Government Analyst Be 18. Mother's Name (First Middle, Roeder Jenkins Dorothea Rosder 17. Father's Name (First, Middle, Last) and Mental I ပ Benjamin Alexander Jenkins injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Randolph Rd., #228A. Silver Spring, Maryland 20904 If item 27 Sarah K. Jenkins - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Department Important: If any injury or once. Lincoln Crematory 02/13/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 1 Year Coronary Artery Disease S—uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examin Hypertension The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No this certificate has death?
1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation impletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the F only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sita Krishnamoorthy,

31. Date filed (Month, Day, Year)

M.D.,

D38139

12204 Plum Orchard Drive, Silver Spring, MD 20904

February 08, 2012

12-01091 Othello Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Othello Jones			tate of Maryla							giene		201	2	05665
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Medical Exami	ner	Othello Jon								February		ounty of Dea		07 1115
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Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	Days	Hours	1.00			Fore	eign	
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b	- }	Usual Residence of Decedent 10a. State 10b. County		I10c City	. Town or Locati	00	_			-			10d Ir	nside City Limits
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Maryland 28a-f show 1 at once.	ই		Mary's	P1	ney Po						100			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		16602 Piney)67				US			
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21215-0036 uild be filed within 7 Mental Hygiene. marked other than c event, the Medical	P B	19a. Informant's Name/Relation	_		19h Mailing	Address (_			- 4	or Town, Sta	te Zin Co	ode)
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/ /Medical Examiner	Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a b. Due to (or as a c.	consequence of	vascular Dise of): of):	9358					Di	sease		veen Onset and Death
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OX 6876 eath certificat : attending ph	Physician/M		he 1 Live b 4 Pregn known 9 Unknown	ant at time of de	2 Fet eath 5 Oth	al death ner (Specify) _	Ectopic p			М	Date of deliver	Day	Year
P.O. es that the igned by be detacl	by F	Part II. Other significant condi	tions contributing to	death but not i	esulting in the u	nderlying ca	iuse giv	en in Part	. I.		_			Unknown
Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d ars after death. *I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	Completed								_				completi	ndings available ion of cause of
Vital Rec ysician: The l his certificate l director, page	BeC	25. Was case referred to medical	al			26.	Place o	f Death (C	heck onl	y one)				
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Certification:	3 Suicide 6 Cou	28e. Place (Specify)	e of Injury - At h	ome, farm, stree	t, factory, of	ffice bui	lding, etc.	28	or Town,		Number or F	Rural Rou	te Number, City
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		Victor Weedn MD JD	Assistant Me			. Baltimo	re Str	eet, Ba	itimore	, MD 212	.23			
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Tenneha marie 12-01405 MCDONO-Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. .unk-unk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 17, 2012 0259 hrs Marie **Medical Examiner** 1 en Neha enkins 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Southbound 495 @ Connectitcut Ave Kennsington Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Country) U.S.A Months Days Hours 2-23-1986 Director 384-11-1906 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location NC 1 Yes 2 No SEOW Ittimore, MD 21215-0036

rit. Pages I and 2 should be filed within 72 hours after death with the Maryland trument of Health and Mental Hygene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 275 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - Americen Indian, Black, White etc. Armed Forces? 1 Never Married 2 No Yes Specify: White 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 65 taura TIVER 17. Father's Name (First, Middle, Last) Maiden Surname) Shawarha uirela Be 19a. Informant's Name/Relationship (Type, Print) Hus beard 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Selma 605 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) resquake Donation 5 Other Specify: 21. Signature of Fylneral Service License 22. Name and Address of Facility Luneral Ltome WHSh., DC ZOOW tacon Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease 2 Multiple Injuries Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last has been signed by the attending physician and 3 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g937 3-4-13 sm X UNPENDED Division of Vital Records, P.O. Box 68760, stal or Attending Physician: The law requires that the death certificate because or the statement of the physician o IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of deliven 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 虿 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page Yes 2 No certificate 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or water within 24 hours after death.

To the Funeral Director: A manufetely filled in by the fu subject driver of vehicle involved in motor vehicle Certification 1 Natural 1 Yes 2 X No Pending fd 2-17-12 fd 02:41 am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Southbound 495 @ Connecticut Ave. Kensington, M 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide determined Interstate/Express 4 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

PENDO 1

State 31. Date filed (Month, Day Year)
Registrar FEB 2 1 2017

Theodore M. King, Jr., MD.

Name and address of person who completed use of death litem 23a)

2. Registrar's Signature

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DOME

February 17, 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		1. Decedent's Name		,							2. Date of De		Day 10	Year	3. Time of Death
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<i>/</i>		Meritus	Medical	Center					stown				Wash	ning	ton
Funeral		5. Social Security No. 213-40-6			. Age (In yrs. Is	ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D		ır)	9. Birt Cot	hplace (State or Foreign untry)
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at at	or	10a. State	10b. County		10c. City	y, Town or Lo	cation								10d. Inside City Limits
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and Healt tem 3		Wayne E. 20a. Method of Disc		s - Husba		1862 Place of Dispo			edsv1		Rd. Boo	_			Z1/13 Town, State
permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.		1 X Burial 2		Removal from S	tate C	emetery, cren	natory or o	other place							
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hysic nis ce il dire	욘	1 🗌 Yes 2 🗔		Hospital:	patient 2 🗆	ER/Outpatier	nt 3 🗆 D	OA Othe	er: 4 🗆 Ni	ursing Ho	me 5 Res	idence	6 🗆 Othe	er (Speci	ify)
ling P	Certificate:	 Manner of Death Natural 	h 5 Pending	28a. Date of (Month)	injury Day, Year)	28b. Time of injury	[28c. Injury work	?	- 1	28d. Describe	how in	njury occurre	ed	
death death stor: / y the	titic	2 Accident 3 Suicide	Investiga 6 Could no	ot be	f Injury - At ho	me farm stre	M And factor		Yes 2	No	20f Location	(Stront	and Numbe	or Pu	ral Route Number,
after after Direct din b		4 Homicide	determin		, etc. (Specify		oct, ractor	y, omoc			City or To			or mur	ai moute numbei,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1	Certifying P	hysician: To the bes	st of my knowl	ledge, death o	occurred a	t the time	, date and	place, a	nd due to the	cause(s	s) and mann	er as st	ated.
the Hi nin 24 the Fu	Med	only one) 3	☐ Certifying N	lurse Practitioner:			death occ	curred at th	ne time, da						ause(s) and manner stated s stated.
No.		29b. Signature and						. License	_	20		29d.	Date signed	1	
)			1 AMME			00.7		D6	950	<u> </u>			2/10	112	
				no completed cause			,	Road	. Had	rerei	town. M	arv	1and	217	742
Stat	е	31. Date filed (Mont			gistrar's Signat		ade		,	, 0		3			
Registra	r		CD T %	CUIC LA	pand, in	B Age	The State of the S								

			For State	State of Man		epartment of F Ce <i>rtificate of L</i>			0016	05668	
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Jertificate of L	Jean	2. Date of Death	eg. No.	3. Time of Death	
Physician/ Medical			Betty Rae Jacobs Month 2 5 2012 7:28 PM								
	Exami		4a. Facility Name (if not institution, give				Location of Death		4c. County of Dea		
	.d		Atlantic Gene 5. Social Security Number 6. S		cal yrs. last birtho	Berlin	If Under 24 Hrs.	8. Date of Birth	Worcest	thplace (State or Foreign	
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	/land f show ed at	tor	10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits	
	e Mary 128a- notifie	Director	MD Worc	ester	Berli					1 Yes 2 XNo	
	ith th	ral		n D.		10f. Zip Code 218	1 1	11	0g. Citizen of What Co USA	ountry?	
	eath w	Funeral	11 Westminste	12. Was Decedent Ever	in U.S.	13. Was Decedent of Hi	spanic Origin? (Spec	cify Yes or No-	14, Race - Ame	rican Indian,	
95	after de al", or il	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,		If Yes, specify Cuba 1 ☐ Yes 2X No		Rican, etc.)	Black, Whit	e, etc. nite	
38 5-0036	hours natura lical E	lete	15. Decedent's E	ducation	16a. D	ecedent's Usual Occup	ation	-77	16b. Kind of Business		
OD 1938	nin 72 ne. than " e Mec	Completed	(Specify only highest gr Elementary/Seconday (0-12)	College (1-4 or 5+)	li	Give kind of work done of fe. DO NOT use retired)	iuring most of workin	ng			
2 7	Hygier other th	0	12 17. Father's Name (First, Middle, Last)		Ho	memaker I	18. Mother's Name	/Eirst Middle M	Own F	lome	
TOC	be file ental l rked o	힏	William F. How	ard					arshall		
7	should and M is mai		19a. Informant's Name/Relationship (7	ype, Print)	19b. I	Mailing Address (Street a	and Number or Rural	Route Number, (City or Town, State, Zi	o Code)	
ત્ર ટ્રે	nd 2 s lealth m 27		John E. Jacob						Berlin, M		
05/2012 Baltimore	Page 1 and the little in the l		20a. Method of Disposition 1 □ Maurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cemetery.	Disposition (Name of crematory or other place) Of the]	e) !		20c. Location - City or Ocean Pi:	·	
02/05/2012 ■ Baltimore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Edneral Service Licen	Tar de					uneral H		
જું 🛮			23a. Part 1. E. er the disease, or com		e death. Do no					Approximate	
	Physician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition		mohio	ā.				Interval Between Onset and Death	
0	Medical Examiner		resulting in death)	Due to (or as a co							
<u>م</u> [Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of)	:					
	uted Id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C					- V		
7	vate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a co	onsequence of)	:					
31/	cate b	edical		l d							
000	certifi ending use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 Ectopic pregnanc	24		23d. Date of de	livery	
ä	Attending Physician: The law requires that the death certificate be executed at death. **redeath.** **ector: Affer this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	in the past 12 months? 1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 Pregnant at tin 9 Unknown		5 Other (specify)	У		Month	Day Year	
900	that th	y Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying cause giv	en in Part 1.	23e. Did tob	acco use contribute to	the cause of death?	
ر ()	quires quires en sig ould b	ted	Sepsi's	•				1 □ Ye	s 2 No 3 □ P	robably 4 🗆 Unknown	
7. 7. O	has be	Completed by						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of	
	an: The tifficate tor, page	Be Co	25. Was case referred to medical			26. Pl	ace of Death (Check	1 Yes 2	No 1 ☐ Ye	s 2 No	
Better	nysicia nis cer direct	To B	examiner? 1 Yes 2 □ No	Hospital: 1 X Inpatient	2 🗆 ER/Outp	patient 3 DOA Othe	ar.		nce 6 🗆 Other (Spec	sify)	
क्षे व	ing Pl		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Tir ear) inji	ury work	?	8d. Describe how	v injury occurred		
Sign	Attend death ctor: /	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b		- At home, farm	M 1 □ 1, street, factory, office	Yes 2 No	P8f. Location (Stre	eet and Number or Ru	ral Route Number.	
Sacobs	ital or A		4 Homicide determined	building, etc. (S	pecify)			City or Town,	State)		
B	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	se Practioner: To the bes	nination and/or i	investigation, in my opinio	on, death occurred at	the time, date and	I place, and due to the ause(s) and manner as	cause(s) and manner stated.	
•	To th withighter To th		29b. Signature and title of certifier	0		29c. License	number	29	d. Date signed (Mont	h, Day, Year)	
			M'	U		Doc	64120		2/6/8	X012	
_	FIT	6	30. Name and address of person who Afit Zecsham	completed cause of death	(Item 23a) (Ty	pe, Print) Howay Dr	rue Be	vli'u. r	10 218	11.	
	Sta Registr	te ar	29b. Signature and title of certifier M 30. Name and address of person who Africa Zec Show 31. Date filed (Month Day, Year) FEB 0 9 2	012 32 Registrar's	Signatur	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 04, 2012 10:10 pM Gladys Judith Kirstein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15101 Interlachen Drive, Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 578-12-4473 **Director** 1 M 2 X F 92 11/09/1919 Virginia Usual Residence of Deced or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15101 Interlachen Drive, #109 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Gift Shop Owner 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) ျ Samuel Goldstein Gertrude Bursek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5915 Halsey Road, Rockville, Maryland 20851 Linda Gordon - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🜠 Burial 2 🗌 Cremation 3 ื Removal from State King David Mem Grdns | 02/07/2012 Falls Church, Virginia Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the dis-shock, or heart failure Approximate Interval Between 10 Years Immediate Cause (Final Physician/ Aortic Stenosis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical that the death certificate be yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director: After this certification of the Funeral Director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 2 X No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D42777 February 06, 2012 reld 6

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

of Vital Records,

Richard Weinstein, M.D., 18109 Prince Philip Drive, #125, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 09 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{1}_{1}, \overset{\text{Year}}{0}_{1}_{2}$ Physician/ February 6:50 AM Kersh Philip. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport 16628 Johnson Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) **Director** 210-40-2434 1 X M 2 🗆 F 55 12/05/1956 Maryland show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Williamsport Maryland | Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 16628 Johnson Dr. 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 【 Divorced Year or Dates White 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Plumber</u> County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Homer Kersh Virginia Moyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin P. Kersh / Son 8826 Crystal Falls Dr. Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 02/14/2012 | Smithsburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ a botructive hronic 0 disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dilinto (or as a consequence of) cause. Enter Underlying Cause (Disease or injury Exami tran and that initiated events Due to (or as a consequence of) resulting in death) Last burialng physician a as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Nes 2 No 3 Probably 4 Unknown ancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 after death.

Director: After this certificate had in by the funeral director, pag 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and on investigation, in the cause of the cause of the cause of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 13 2012

State Registrar 11:11

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ess of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 February 2:05 Virginia AnnieBelle Koontz Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington 35 W. Frederick Street Williamsport 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days (Month, Day, Year)
March 26,1943 Maryland 1 - M 2 X Months Hours 216-38-2449 68 **Director** Usual Residence of Decedent 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Williamsport Washington 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 35 W. Frederick Street 21795 USA items ? 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give permit. Page 1 and 2 should be filed within 72 hours aft Department of Heath and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: 3 X Widowed 4 Divorced Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Leather Processing Cutter Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Walter Woodrow Zeger Edith Virginia Harsh 19a. Informant's Name/Relationship (Type, Print) (Daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 W. Frederick Street Williamsport, MD 21795 Rayetta A. Schetrompf 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Crematory Feb. 13, 2012 Hagerstown, Maryland Hagerstown 22. Name and Address of Facility Osborne Funeral Home P.A. Signatu 425 S. Conococheague St. Williamsport, MD 21795 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death lock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_j sician/ disease or condition resulting in death) Due to (or as a consequence of): 4 month Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or impury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death 1 Yes 2 9 Unknown detached g 🗌 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ge 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate 1 Yes 2 No 2 1 No Yes pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar Mas

31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0903M Ò Murie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis AAMC Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min 046-14-8081 Director 1 □ M 2XX Vrc 7/24/1924 CT Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director notified MD Anne Arundel Harwood 1 Yes 2XXNo 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Examiner must be 23a Funeral 20776 4187 Solomons Island Rd. USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2XXNo
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: Completed 3 ₩Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marjorie Stace Howard Kashman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trat York, PA 17404 10 Nursery Lane Patricia Moore 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Cathedral Cemetery 2/13/2012 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MONARI STRUCTIVE Physician/ ONIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): sician a burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phys the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Year Month Pregnant at time of death 5 Other (specify) the 9 | Ilnknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 Yes 2 No this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ER/Outpatient 3 □ DOA ၉ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d, Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 10:40 PM 9, SUZANNE KELLER-APPERTI February /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F 08/19/1934 Virginia Director 223-42-0203 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5212 Debra Road 21817 U.S.A.

14. Race - American Indian, Funeral permit. Pages 1 and 2 should be filed within 72 hours after deai. Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic excess. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Assistant Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fvie Ellis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hollar 19a. Informant's Name/Relationship (Type. Print) 5212 Debra Drive - Crisfield, MD 21817
Disposition (Name of Date 20c. Location - City or Town, State Michael J. Apperti, Jr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 02/12/2012 Delmar, DE 21. Signature Theral Service Lice

22. Name and Address of Facility

23. Name and Address of Facility

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29. Name and Address of Facility

2 306 W. Main St. - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ZNo 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. been signe should be c ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown MONARY EMBOLUS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 48098 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARUMBUNATHAN 201 HALLHIGHWAY, CRISFIELD -VIJAY 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

FEB 13 2012

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ND#26perMD,2/8/12;BMW,McCo Certificate of Death Reg. No. 2 | | 2

				aryland / Depa			Mental Hyg	giene			
			= State Registra MEND#26perMD, 2/8/12; EMW, M	cco Cer	tificate of L	Death	F	Reg. No. 🤈 🦳	2 05674		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deam Month	Day Year	3. Time of Death		
	Medic		Helen Jane Kimber				Februar		3:30 ам		
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Death	1	4c. County of De	ath		
	x"		10407 Proctor Street			r Spring		Montg			
	Funeral		. □	e (In yrs. last birthday) 88 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March I	9. E	Sirthplace (State or Foreign Country)		
	Director		474-14-7146 1 M 2 M F S	oo rrs.			March I	1, 1923	MN		
	nd how at	=	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits		
	aryla a-f s ified	š	MD Montgomery	Silv	er Spring	7			1 Yes 2X No		
	or 28	늅	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Sountry?		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10407 Proctor Street		20901			USA			
	ems ems	ڃٙ	11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Am	nerican Indian.		
9	or it	by	Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒	No			o Rican, etc.)	Black, Wh			
ဗ္က	ırsaf ıral", IExa	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	I□Yes 2∄No	Specify:		Specify: Wh	ite		
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Maryland 21215-0036	d 2 should be filed v alth and Mental Hyg 127 is marked othe er traumatic event,	To B	17. Father's Name (First, Middle, Last)				ne (First, Middle, N	Maiden Surname)			
ž	uld build bu		Edward E. Anderson			Alice E					
Jai	should and 7 is m		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, 2	•		
a î	and 2 Health em 2 ther t	- 3	Joseph S. Kimber/Husband	1		Street, S	ilver Sp	ring,MD 20			
0	Page 1 annent of Hant of Hant: If ite	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	(e) Fe	Date b 9	20c. Location - City of	or Town, State		
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Baltimore,	permit. Page Department Important: I any injury o	l i	21. Signature of Funeral Service Licensee	22 F r	. Name and Addres	ss of Facility	Funeral	Home Inc.	ng, MD 20901		
_	00=00		James & Doods						ng, MD 20901		
			23a. Part 1. Eater the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between		
	Physician/	8 9	Immediate Cause (Final disease or condition	1 Debili	M				One t and Death		
	Medical Examiner		resulting in death) Due to (or as a	consequence of):	0			, 3			
	_xammo.	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.								
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ň	e death the atter	Physician/M	1 ☐ Yes 2 🗖 No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)						
	requires that the death certific been signed by the attending should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?		
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ပ္က	has l	mp	Dyphagia			4a. Was an autopsy performed? 24b. Were autopsy prior to completion of codeath?					
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>	Phys this al dir	<u>۔</u> 1	1 ☐ Yes 2 ☑ No 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur	nt 2 ER/Outpatien y 28b. Time of	* 3 □ DOA	4 L Nursing H		ence 6 Other (Spe	ecify)		
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24a. Was a autor performed by the standard of							Street and Number or Rural Route Number, vn, State)				
2	spital ours leral filled	cal	29a. Certifier 1 Certifying Physician: To the best of r	ny knowledge death o	occured at the time	date and place, a	nd due to the caus	se(s) and manner as s	tated		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the populated filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Examiner: On the basis of ex	amination and/or invest	igation, in my opinio	n, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.		
only one) 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(see 29b. Signature and title of certifier 29c. License number 29d. Date 29d. Da							9d. Date signed (Mon				
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type P	rint)			2-6-20	10		
				800 Tech	, Rd #	-240 S	ilver Sor	ing Md.	20904		
	Stat	е	31. Date filed (Morith, Day, Year) 32 Registral		00			0			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State ME nd #3 per fh 02/14/12 pertificate of Death 2. Date of Death Physician/ 2012 A M Mildred L. Kelly February 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Bradford Oaks Nursing Center Clinton Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 □ M 2 🛂 F Days Hours Min. **Director** 94 Missouri 492-20-8836 Jan. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🎦 Yes 2 □ No Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 8309 Highgrove Court 20695 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Black Completed 3 → Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important, If item 27 is marked other than ' $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Sales Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) King David Bryant Sarah Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra McKenzie - Daughter 7205 Joplin Street Capitol Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 8 1 → Burial 2 □ Cremation 3 □ Removal from State ò injury (4 ☐ Donation 5 ☐ Other (Specify) 2012 Fort Lincoln Brentwood, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licenses 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? page certificate ! 2 No 1 Tyes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) 24 hours Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certify

Michael G. Sidarous

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

D45365

11701 Livingston Road Ft. Washington, Maryland

29d. Date signed (Month, Day, Year) 8/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#6 per FH State of Mary State 2/8/2012 AACOHEAUTH CMH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician/ 9:28 JR. LEONARD 201 DANNIE J JAN 06 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONTGOMERY BETHESDA WRNMMC 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1*6725*71958 Unknown 1 XM-2 X 53 251-15-6281 Director Usual Residence of Decedent 10d Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🏝 No Ft. Meade Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral **USA** Unk. Unk. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married x Yes 2 □ No 1977 Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 1996 If Yes, Give other than "natural", vent, the Medical Exa 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Military US Army Sergeant permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ UNK. UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8901 Wisconsin Ave., Bethesda, MD 20889 Robert Weiler - Patient Admin. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 2/8/2012 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signatu 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed? 1 🗌 Yes 2 🗌 No

or Attending Physician: The law requires that the death certificate be executed page 2 within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral

Be

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Certificate:

Medical

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify)

Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

0102202848

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WRNMMC, BETHESDA, MD 20889 5600

State

To the Hospital

PUMERANTZ AARON W. 08 2012

egistrar's Signatur

Registrar

completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LOPEZ NRIQUE Month O 2 Physician/ 610 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annape 13 Medical Center Anne Arundel 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** (Month, Day, Year) Country 548-38-1834 78 **Director** 1**X**M 2 □ F 11-13-1933 Texas 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ¥ Yes 2 ☐ No Prince Georges 10f, Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a USA 20716 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White etc ō þ 1 Never Married 2 Married 1 XYes 2 No Specify: Mexican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1952-56 Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 I n and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) မ ENRIQUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20716 WiFe 12712 Bowie Lane 20a. Method of Disposition 20b. Place of Disposition (Name of ➤ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Cheltenha ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 200 CC0342 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between INTRACEREBRAL Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner EARS MA TICOAGULA TION Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury FI BRILLATION MRS TRIAL as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical HIN EARG Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) en 21438 M Ch 022012 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY NNAPOLIS MD21401 MICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

		1	For State		State of Ma	aryland /		artment of F <i>tificate of E</i>			giene Reg. No	21111	2 05678
			riegiotal						2. Date of De	ath		3. Time of Death	
Physician/ Medical MANIJ LIU									02/07/	<u>2012</u>	y Year	9:05 A M	
eren	Examiner 4a. Facility Name (if not institution, give street and number)							4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery		
	770 Clifftop Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)				thday)	If Under 1 Year	If Under 24 Hrs.	Irs. 8. Date of Birth 9. Birthplace (Sta			irthplace (State or Foreign		
	Director		227 00 2070							nina			
	how at	Funeral Director	Usual Residence of I 10a. State	Decedent 10b. County		10c. City, Tov	n or Loc	ation				-	10d. Inside City Limits
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	r deat or iten niner	by Fu	 Marital Status Never Marrie 	ed 2 X Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S _i ın, Mexican, Puert	oecity Yes or No- o Rican, etc.)		14. Race - Am Black, Wh	
98	rsafte rral", o Exan		3 Widowed 4		If Yes, Give Year or Dates.	140	1	Yes 2 No	Specify:			Specify: Ch	inese
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72	ithin 7 ene. r than	Completed	Elementary/Seco	onday (0-12)	College (1-4 or 5		life. DO ler k	O NOT use retired)			Tra	ading C	ompany
<u>ک</u>	iled w Il Hygi other	B B	17. Father's Name (F	irst, Middle, Last)	unk				18. Mother's Na	me (First, Middle	, Maiden	Surname) u	nk
ylar	ld be i Menta arked atic e	유											
Maryland 21215-0036	shou hand 7 is m traum		19a. Informant's Nar					g Address (Street a					
<u>မ</u>	and and the Healt tem 2		20a. Method of Disp	Lang/hus	<u>bana</u>			sition (Name of natory or other place		Date	T	ocation - City	
E E	Page 1 nent of int: If i		1 XBurial 2 ☐ 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State (y)			natory or other plac Memorial		11/2012	Roc	ckville	, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be		21. Signature Fun		~	en y	22	. Name and Addres	ss of Facility S				
		Н	23a. Part 1. Enter th	ne disease, or com	plications that caused	the death. Do						110 / 12	Approximate
	hysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Advanced Heratocellular carcinoma Advanced Heratocellular carcinoma										
Medica Examine			resulting in death) Due to (or as a consequence of):										
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<u>:</u>	al or A s after Il Dire												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriathingly.	Medical	(Check 2	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination and	or inves	tigation, in my opini	on, death occurred	at the time, date	and plac	e, and due to th	e cause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Angela Livingston_Alston 21:25 M 01 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandari<u>n House Hospice</u> Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days Hours 578-88-0305 1 🗆 M 2 🗷 F 48 10/19/1963 Washington, DC 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Z Yes 2 No MD Prince Georges Capitol Heights 10e. Street and Number 10a. Citizen of What Country? 70th Street 20743 USA Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 🗷 No 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Mae Evans Livingston Clarence Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 Barnaby Terr., SE Washington, DC 20032 <u>Wilfreda Suggs - daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Cemetery 2/7/12 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W H Bacon Funeral Home 3447 14th ST NW Wash., DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death months CA Cervix resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Month Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

Physician/ Medical Examiner Examine

Physician/

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Examiner

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Baltimore, Maryland 21215-0036

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Physician/Medical

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Certificate:

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29a. Certifier

(Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

in the past 12 months?

1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation

Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Mame and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Data signed (Month, Day, Year)

ANNAPOLIS, M.D. 21401

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NEVIEWE 31. Date filed (Month, Day, Year,

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within 24 hours after de To the Funeral Director

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Examiner	44. Facility Name (it not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death	4c. County of Death	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 20b. Place of Dispo			
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Box death c death c death c	in the past 12 months? 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 1 Ves 2 No	Ectopic pregnancy Other (specify)	Month	Day Year
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Division of Division of Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certificate:	29a. Certifier (Check check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death only one) 1 ☐ Medical Examiner: On the basis of examination and/or investigation only one) 1 ☐ Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at the	time, date and place, and due to the ca	ause(s) and manner stated.
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
10	30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) ANHA P. Chett	4, M.D.	ک
	8600 old beorgetown Rd B	thusda no 20	0814	
State Registrar	31. Date filed (Month, Day, Year) FEB 0 9 2012 33. Registrar's Signature 5. Am	as.	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Ellen Logan February 2012 4:30 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 45168 Irving Place Callaway St. Mary's Social Security Number 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 217-32-4535 **Director** 1 M 2 K F 75 July 10, 1936 Maryland 28a-f show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Callaway 10e. Street and Numbe 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 45168 Irving Place 20620 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Hygiene. other than "natural", or iter ent, the Medical Examiner. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. by 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker other 1 Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ည Joseph Vernon Stone Mary Mildred other traumatic Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or an Joyce A. Sanders 44075 Medley's Neck Rd. Leonardtown, MD Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Mattingley Gardiner Funeral Home, P.A. Crematory, 02/14/2012 Leonardtown, MD 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lot see Address of Facility Mattingley—Gardiner Funeral Home, P.A
 41590 Fenwick St. Leonardtown, MD 20 Victorett Jardine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ensive Cardiovasular Discess Ph sician disease or condition Medical resulting in death) to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ ò Dav Pregnant at time of death Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 24 hours after death.
Funeral Director: After tetely filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 **To th**e I 29b. Signature and title of certifier 021893 KMH. Bundes, In). 13/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5) eme Roy H. Bunales, M.D. 22335 Exploration Park Dr., Lexington Park, MD 20653 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State **FEB 1 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February DaO4 2012 Physician/ 08:55 A M Alexander John Lemanski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 04/15/1931 **Director** 027-24-9873 1 X M 2 D F 80 Massachusetts 2 should be filed within 72 hours after death with the Maryland th and Mertal Hygene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MA Palmer 1 Yes 2 No Hampden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 01069 United States 1045 Circle Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married by X Yes f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify 3 Widowed 4 Divorced Completed 1952-54 White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Salesman Warren Pumps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alexandra Zajk Boleslaw Lemanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n any injury or other **** 1045 Circle Drive, Palmer, MA 01069 Joanne Lemanski/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place akemont Memorial Gardens | 02/08/2012 Davidsonville, MD 4 Donation 5 Other 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_si_ian our cel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) Exami death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Cther (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 certificate has 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 1 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director, After this of completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural Natural 5 Pending Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 2-4-2012

State

10-1

Registrar
DHMH 17 Rev 06-2011

Desense

Annapolis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

445

Registrar's Signa

69/Capin

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2012 John L1ovd 8:13 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Center Annapolis Anne Arundel <u>Anne Arundel</u> Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral Hours Months 08-24-1927 Wash. Director 218-24-0191 84 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Calvert Dunkirk 10e. Street and Numbe 10g. Citizen of What Country? Funeral "natural", or items 23a 1432 Knight Avenue 20754 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 11 Printing Specialist US Census Bureau marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Thomas Llovd Ellen Rebecca Purdy 19a. Informant's Name/Relationship (Type, Print) item 27 is r other traun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1432 Knight Avenue, Dunkirk, <u>Genevieve Lloyd, spouse</u> MD20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 02-06-2012 Owings, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ d X disease or condition Medical resulting in death) Due to (or as a c nse uence o Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury **the Hospital or Attending Physician:** The law requires that the death certificate be executed thin 24 hours after death. the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Dav signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has | completed filled in by the funeral director, page 2 s autopsy performed Yes 2 No Be 25. Was case referred to roodical 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မ 1 🗌 Yes 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHSOOB YEI naboli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Year Norman Lucas 2012 0615 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AAMC Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth Hours **™** M 2 □ F 323-22-3319 (Month, Day, Year) 7/14/1929 **Director** 82 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xXNo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2794 Topmast Ct. 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force 0, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give 1 Yes XX No Specify: White "natural", Completed 3 Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Manager Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Vincent Lucas <u>Harriet Arnesen</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Mary Lucas West Daughter</u> <u>3698 Tanglewood Lane Davidsonville, MD 21035</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2/7/2012 Glen Burnie, MD 21. Signature of Funeval Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ COPD disease or condition resulting in death) exacer bahin Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated npleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) 02 D0072371 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SNYDER lonathan 2001 Medical Parkway Annapolis, MD 21401

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

FEB 0 9 2012

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20\overset{\text{Year}}{1}$ <u>Shirley Faye Lewis</u> 8:43 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 210 Longfellow Drive QueenAnne Chestertown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 220-28-4576
Usual Residence of Decedent Director 1 M 2 X F 77 1/14/1935 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified - 28a-f 1 🗌 Yes 2 🏻 No Cambridge Dorchester 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral 954 Hudson Road 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 🕱 No If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Completed 3 ♥ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Librarian Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Leon Hurley Lucy Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2: <u>Julie Townsend/daughter</u> 210 Longfellow Drive, Chestertown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) John's Cemetery ! 2/16/2012 Cambridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 308 High St. Newcomb and Collins F.H.Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. E. t., Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defected for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 pronths?

1 Yes 2 No Month Year Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe _ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: DAUGHTERS 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) RESIDENCE Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending wor⊦ 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: A completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

State

8221 Teal Drive, Suite 302, Easton, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

David H. Smith, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joel LEVY Month 2012 January 4:10 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Irish Court Gaithersburg If Under 8. Date of Birth (Month, Day, Year Nov. 3, 1 9. Birthplace (State or Foreign Country) Canada If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 1 **X** M 2 □ F Hours 151-18-3045 88 **Director** Nov Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 20878 5 Irish Court within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married Black, White, etc. þ ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Operations Research Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Drazin Samuel Levy 19a. Informant's Name/Relationship (Type, Print)
Gail Levy, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irish Court, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 01/27/12 Olney, MD 21. Signature of Fundral Service Li TarehinskyssHebnew Funeral Home 010081254 Carroll St., NW, Washington, DC 20012 Part 1. Safer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Ph_{sician}/ Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Chronic Renal Disease Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last ending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 26, 2012 D 0035859 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20877

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 3 0 2012

Registrar's Signature

Leszek Karowiec, M.D., 501 N. Frederick Ave., 2nd Floor, Gaithersburg, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Ida Louise Chambers Love 2/2/2012 Day 1040 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Hebrew House Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs, last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 TXF Texas Days (Month, Day, Year) 300-14-4029 101 Director 9-26-1910 Usual Residence of Decedent 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Rockville 1 Yes 2 No Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10819 Brewer House Rd. 20852 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 ☐ tho Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced Year or Dates Black 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked otl 2 Booker David Chambers Bertha Lucretia Crunk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Love-daughter 10819 Brewer House Rd., Rockville, Md. 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 2/6/2012 Hanover, Md Crematory Signature Funeral Service License 22. Name and Address of Facility Snowden Funeral Home N. Washington St., Rockville, Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Advanced Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Jath Cer ...
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State

Registrar

31. Date filed (Month, Day, Year)

FEB U7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 05688 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 <u>Lisa Ann Law</u> February 1:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Harwood Anne Arundel Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Hours Min **Director** 214-80-4064 1 - M 2 XF 46 Usual Residence of Decedent Dec. 1, 1965 Potomac, Maryland show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 X No Maryland Prince Georges Bowie ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 15111 Roving Wood Drive 20715 United States items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Narried by be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: Caucasian Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Broker Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other traumation 2 Arnold Salus Roslyn Rudden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan O. Latt, Cousin 4401 Pinetree Road, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 02/03/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute 21. Signature 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician 9 reno curtical a Carcinyma disease or condition 520 resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a son sequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami R Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as nding IF FEMALE asn 23c. If yes, outcome of pregnancy
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To the Funeral C

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 E Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	Yhysi	this o		1 Pes 2 100 1 Inpatient 2 12 ER/Out	patient 3 🗆 DUA 4				cify)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	o ling	After funer	ate	1 Natural 5 Pending (Month, Day, Year) inj	ury work?		8d. Describe how in	jury occurred					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	ttenc	tor:/	iji	3 Suicide 6 Could not be									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	or A	arrer Direc in by	हु	4 Homicide determined 25e. Place of Injury - At home, fame building, etc. (Specify)	n, street, factory, office	2			ral Route Number	r,			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	pital	eral filled		202 Cartifier Cartifying Physicians To the best of my knowledge of	andle and comment at the time of		d along 4 a Along and 1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	Hos	Fun Fun etely	edi	(Check 2 imedical examiner: On the basis of examination and/or	investigation, in my opinion, di	leath occurred at t	he time, date and bla	ace and due to the	cause(s) and mann	ner stated.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043	o the	O to the											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043		- 40		Alman tarm		_							
Summit Gupta, MD 3000 North Ridge Road, Ellicott City, MD 21043			ŀ	30. Name and address of person who completed cause of death (tem 23c) (5	N 1/4	1.1.	Fel	bruary 7,	2012				
						cott Cit	v. MD 217	043					
Registrar FEB U 8 2012 Characa A. Alamana A.		Stat	е				<u> ۱۱۱۰ کست</u> و ر	U T J					
				FEB US 2012 Cerus A. A	all all all all all all all all all all								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 201^{Year} JOHN FREDERICK MOHR 5:45PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel South River Nursing and Rehabilitatio Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 090-22-2285 83 Director 1 🛣 M 2 🗆 F 7/9/1928 NY Usual Residence of Deceden or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😿 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 304 Hilltop Lane #E 21403 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 X Yes 2 □ No If Yes, Give Year or Dates. 1 Never Married 2 x Married 1946 Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1950 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Master Sergeant US Air Force Reserves permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Mohr Ivy Lucy Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Mohr / Wife 304 Hilltop Lane #E, Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify Kalas Crematory 2/6/2012 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home Signatur 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lumphome Hodgkins Ph sician/ NON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Day to (or as a nunsequence of) If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI) 1/eur DUUS 37 U 9

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registr*a*r Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Adali Alejandra Feb.4,2012 Monzon 0545 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Months Hours Mantry) none 2/04/2012 Director Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Spring Silver Montgomery MD 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be Funeral 23a 1 and 2 should be filed within 72 hours after death with 3520 Greenly 20906 Street USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Guatemalan 1 X Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed edical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than ' ent, the Me Elementary/Seconday (0-12) College (1-4 or 5+) none none other Be 18. Mother's Name (First, Middle, Maiden Surname)
Paola Lopez Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever ဂ္ Hugo Monzon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code it of Health a Paola Lopez/Mother 3520 Greenly Street Silver Spring, Md 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven õ 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or 2/9/2012 Silver Spring, Md 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of PHYTETPAdes RINALDI FUNERAL SERVICE, PA 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Extreme prematurity disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) as the burialattending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 s autopsy performed Yes 2 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

Barbar J.Butler MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd Silver Spring, Md

Feb. 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 02/02/2012 CAROLYN LOUISE MATTHEWS 4:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD **Funeral** 6. Sex 7 Age (In vrs. last hirthday) 8. Date of Birth 1 □ M 2 🔀 F Days Hours (Month, Day, Year) 10/21/1945 **Director** 66 215-46-0448 r 28a-f shown notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 SyYes 2 No MD Sandy Spring Montgomery ö 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 20860 USA 18506 Chandlee Mill Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than ' Elementary/Seconday (0-12) Montgomery General College (1-4 or 5+) 12th Nurse Hospital Be 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked of other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Julius Matthews Corrine Louise Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18569 Brooke Rd., Sandy Spring, MD 20860 George Matthews/son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1½ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ash Memorial Cemetery 2/11/2012 Sandy Spring, MD 22. Name and Address of Facility Snowden Funeral Home, P.A. Funeral Service Line 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Gangrene disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Peripheral vascular disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) T and certificate be executed Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Dav Year 9 Unknown 9 | Inknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encephalopathy 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown End stage renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2X No To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate h 1 Yes 2 X No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔯 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 XNursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

1

FEB 09 2012

31. Date filed (Month, Day, Year)

Summit Gupta, MD

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D68890

29d. Date signed (Month, Day, Year)

02/07/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Mandy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death enter a If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months Days Hours Min. (Month, Day, Year) Country) **Director** 70 5355 62 Usual Residence of Decedent show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 XYes 2 No MD Charles Waldorf 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3189 Shadow Park Lane 20603 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc. 1 Never Married 2 Married filed within 72 hours after ☐ Yes 2 🔀 No 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 3+ Management Specialist H.U.D Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked Lester Mandy Sadie Shellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3060 Continental Colony Pkwy Atlanta,GA30331 Sadie E.Gardner/ Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake 2/8/2012 Crem Beltsville MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Briscoe-Tonic Funeral Home 294 Old Washington Rd. Waldorf 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onlet and Death Failure Physician/ disease or condition Medical resulting in death) Examiner veekus fusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ravo Merinal attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Year Month Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performe death? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Director: After 28d. Describe how injury occurred 1 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Yes 2 🗌 No Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier only one Certifying Nurse actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 246419

State Registrar Cause of death (Item 23a) (Type, Print)

strar's Signature

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Emily Ruth MARTIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Unde **Funeral** Min Days Director 255-68-3773 Usual Residence of Dece 1 □ M 2 😿 F 67 Dec. 27 1944 North Carolina 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Md. Washington Hagerstown 5 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 227 W. Franklin Street 21740 Apt. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", Specify: White Completed 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) n Cashier Fast Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ပ္ Betty Mae Walker Ervin Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 3528 Chestnut Grove Rd. Keedysville, Md. 21756 Virginia Woods - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/14/2012 Hagerstown, Maryland Signature of Funeral Ser 22. Name and Address of Facility Minnich Funeral Home Kulit 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caus a the death. Do not enter the mode of dy such as cardiac or respiratory arrest, Approximate Interval Between Oncet and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mont s' 1 Yes 2 No Year Pregnant at time of death detached the Unknown P.O. ģ Part II. Other significant condition signed 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page this certificate 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ည ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funer on of the funer of the function of the funer of the function of the funer of the function of the funer of the funer of the funer of (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical

State Registrar

29a. Certif

29b. Signal

30. Name and address of person who completed cau-

To the I

of death (Item 23a) (Type, Print

Medical Examiner: On the basis of examination and/or investigation, in

egistrar's Signati

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edwin Lee McKay 11:56 a.m February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 220-34-7870 (Month, Day, Year) Director 1 X M 2 🗆 F 73 11/22/1938 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f Maryland St. Mary's California 1 Yes 2 No ms 23a or must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23247 White Birch Court, Apt. 130 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner ı 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 🗷 No Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Clerk Civil Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Joseph Norman McKay Mary Helen Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619 <u> Alberta J. McKay/Wife</u> 23247 White Birch Court, Apt.130, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö 1 Burial 2 Cremation 3 Removal from State Department Important: Il any injury or once. John's Cemetery 02/16/2012 4 ☐ Donation 5 ☐ Other (Specify) St. Hollywood, MD 22. Name and Address of Facility Brinsfield Funeral Home Signature of the state of the s 22955 Hollywood Road, Leonardtown, MD .Ir M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Due to (r as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autor performed? Yes 2 No 1 🗌 Yes 2 🗷 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at eral Director: After if filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lows hon 02/11 D64289

Registrar
DHMH 17 Rev 06-2011

State

4) RMG

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32. Registrar's Signature

SURRATTS ROAD, CLINTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2012^{Year} Physician/ McPHERSON MARLENE FEB 3:00PM M 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHEVERLY PRINCE GEORGES HOSPITAL P.G. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 ☐ M 2X F 578 58 WASH. DC 1938 SEPT 7 73 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MT.RAINIER P.G. 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2707 UPSHUR STREET #2 20712 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me FED. GOVERNMENT Elementary/Secondary (0-12) College (1-4 or 5+) MAN POWER DEVELOPMENT SPEC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PRESTON E. ROBINSON SR. WILHELMINA GALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 INDO PLACE LANDOVER MD 20785 DONJA M. HARRIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BRENTWOOD MD 4 Donation 5 Other (Specify) 2/10/12 LINCOLN CEM. 21. Sign ur Funeral Service License 22. Name and Address of Facility WATSON FH 3435 14th ST. NW WASH DC 20010 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Heavt Failure ungest Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or injury Diabetes as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 2 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 No မ Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after used...

To the Funeral Director: After this controletely filled in by the funeral di ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu D00223300

Registrar DHMH 17 Rev 06-2011

State

son who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 28, 2012 Patricia Ann Madison 10:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 20 Ridge Road Unit L Prince George's Greenbelt 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-52-5213 **Director** 1 □ M 2**X**□ F 72 Dec. 1, 1939 Washington, DC Usual Residence of Decede show 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Prince George's |Maryland Greenbelt 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? be must be Funeral 20 Ridge Road Unit L 20770 USA . Page 1 and 2 should be filed within 72 hours after death riment of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items lant: If item 27 is marked other with the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic event, the Medical Examiner multury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: 3 ★ Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sanitation company 11 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rudolph Schultz Cansada S. McMullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Lois Gaye Houchens/ Daughter 12508 Thompson Road Bowie, MD 20720 20b. Place of Disposition (Name of compatery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State Huntt Crematory or other 2/3/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 2 e Physician/ Chronic Obstructive Pulmonery disease or condition Vear Medical resulting in death) Due to (or as a consequence of) Examiner sign, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ned by the a 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ochronic Pulmonary Infection Due to Mycobacterism Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown avrin - intracellulare Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in till opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifie

Louis

Steinberg

31. Date filed (Month, Day, Year) FEB 03 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

1-30-2012

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neral		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annap If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Day	h	9. Birthp	lace (State or Foreign
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in by the f	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		Yes 2 No	28f. Location (Si City or Town		ber or Rural	Route Number,
completely filled in by the funeral director, page	Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death or (Check 2 Medical Examiner: On the basis of examination and/or investigation.)	gation, in my opini	on, death occurred at	the time, date ar	nd place, and d	ue to the cau	se(s) and manner stated.
сошр	Σ	only one) 3 Certifying Nurse Practitioner To the best of my knowledge, and signature a	29c. Licens		2	29d. Date sign	ed (Month, E	ay, Year)
		30 Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)	1)	<u> </u>	A POLIS		022012
Stat gistra	e	31. Date filed (Month, Day, Year) FEB 06 2012 32. Degistrar's Signature	CFENSE	1,009	[[14 10 1	17 0(1)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month GREIA 2:54 A 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death PG Ft. Washington Ft. Washington Hospital Ctr. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 235-60-3710 1 🗆 M 2 🕱 F 71 2/2/1940 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Waldorf Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 USA 8741 Valley Dr. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married White If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetology Beautician 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Frances Jones Otto Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8741 Valley Dr. Waldorf, MD 20603 <u>James Munsey/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2012 Cheltenham, MD Veterans Cemetery Signature of Funeral Service License 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death SUDDEN CARDIAC disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery

Physician/ Medical Examiner

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Baltimore, Maryland 21215-0036

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items 23a or ner must be r

burial-tran attending physician the as use director, page 2 should has certificate Phospital or Attending Physician: 24 hours after death. Funeral Director: After this certific filled in by the funeral

death certificate be P.O. Box 68760

Division of Vital Records,

Exami

Completed by Physician/Medical

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Certificate:

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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IF FEMALE:

23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? RITEUMATOLD ARTHRITIS 24a. Was an BREAST - TREATED perform CANLER 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 00A 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

>> 46345

3510 Old Washington Pd, Steroo, Waldorf, MD 20602

29d. Date signed (Month, Day, Year) 01-31-2012

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State Registrar

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Physicia Medic		Harold James Ma	rlowe					Jan.		1 2012	ar	7:40P M
Examin		4a. Facility Name (if not institution, g				4b. City, Town, o		eath		c. County of E		
Funeral		Clinton Nursing 5. Social Security Number 6		e (In vrs. la	ast birthday)	Clinton If Under 1 Year	If Under 24 F	Irs. 8. Date of Bi		rince (ge's
Director		231-52-6828	1 XX M 2 □ F	70	Yrs.	Months Days	Hours M	lin. (Month, D	ay, Year)		Country	1)
br how	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation		12/02	194.	L		yland d. Inside City Limits
Aarylar 8a-f s tified	Director	MD Charle	C		ldorf							1 ¥ Yes 2 □ No
a or 2 be no	٥	10e. Street and Number	5	Wa	Idori	10f. Zip Code		-	_	itizen of Wha	t Countr	y?
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er dea or itel miner	by Fu	11. Marital Status1 ☐ Never Married 2 ▼ Marrie	12. Was Decedent E Armed Forces? d 1 \sum Yes 2 \boxed{\textbf{X}}					(Specify Yes or No erto Rican, etc.)		14. Race - A Black, V	Vhite, etc	0.
urs aft ural",	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.			1 ☐ Yes 2 🔼 No	Specify:			Specify:	vhit.	e
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marke		John Marlowe Jr 19a. Informant's Name/Relationship			1.01			yl Young	0.:	T 0//	7: 0	4.1
12 sho alth an 27 is r trau		France Marlowe/						Rural Route Numb			, ZIP GO	oe)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3			lace of Dispo	sition (Name of natory or other place		Date	_	ocation - Cit	y or Tow	n, State
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permit Depar Impor any in once.		21. Signature of Funeral Service Lice	ensøe	100 01	_	Name and Addre		Huntt Fu ton Rd. W				601
		23a. Part 1. Enter the disease, or co		the death						II, III	1	Approximate
Physician/		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause orneach line		Penati	Cardia	2000	las de	1200			nterval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a	a consequ	ience of):	11	1.	lar de				
LXdiiiiioi	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ		melle	Ws				-	_
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cate be physici s the bu	Physician/Medical		d								_	
Attending Physician: The law requires that the death certificate be redath. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy					23d. Date o	f deliver	
death of	sicial	in the past 12 months? 1 Yes 2 No	4 🔲 Pregnant a			Ctopic pregnand Other (specify)	ру ————————————————————————————————————			Month		yay Year
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requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	s contributing to death b	ut not res	uiting in the u	indenying cause gr	ven in Part I.			_		cause of death?
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Physician: this certifica	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatier		4 Mursin	g Home 5 Res			pecify)	
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of eaurse Practitioner: To the	xaminatior	and/or invest	tigation, in my opinio	on, death occurr	ed at the time, date	and place	e, and due to	the caus	e(s) and manner stated
To the within To the comp	2	29b. Signature and title of certifier	disc i facultoner. To the	0 0031 01 11	ly Knowledge,	29c. License		la piace, and due to		ate signed (M		
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Stat	e	31. Date filed (Month, Day, Year) FEB 0 7 201	Ace P.C. 12 32. Registra	ar's Signat	ure /	ne center	JULIE J	2 walder	(1)	W 20	00/	
Registra	r	FEB 0 7 201	Langa	A.	are park							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nomia Lois Mowbray February 6 201^{e2} 9:45 pmM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 ⋤ F Months Hours 218-34-9548 Jan. 14, ^{Year} 1934 Maryland 78 **Director** Usual Residence of Decedent fshow 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 Academy Street 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0. Black, White, etc. 1 Never Married 2 Married Yes 2 No white 1 Yes 2 No Specify. If Yes, Give "natural" 3 X Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene item 27 is marked other than "natur other traumatic event, the edical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles E. Harris Sr. Lydia Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Guy B. Mowbray son 513 Academy Street, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ò 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury Maryland Veterans Cem! 2/10/12 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. . Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Physician/ obstructive Chronic disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the bunal-transit Due to (or as a consequence of). Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hospital or Attending Physician: The law requires 1 XYes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 2**X** No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowled and title of certifier H0059973 and address of person who completed cause of death (Item 23a) (Type, Print) Bramble St Cambridge, MD 100 whnson

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month 02 Physician/ 6:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death River ster Kent town Birthple Country) MD 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F (Month, Day, Min 214 70 6192 Director 55 1956 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Queen Anne Chestertown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1904B Pondtown Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2x No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. sBol/ack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machine Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of William Daniels Williams Betty permit. Page 1 and 2 should k Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Daniels 1904B Pondtown RD Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Boardley Chapel 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) /18/12 Chestertown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home STMD 21620 High Chestertown, 23a. Part 1, Ent I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Stage disease or condition resulting in death) day Medical Due to (or as a consequ ∓ ce of) Examiner Sequentially list conditions, If any leading to immedi-cause. Enter Underlying Cause (Disease or iinjury death certificate be executed ending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown for Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, diserse 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown renal 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an Constigation has page 2 performed Yes 2 L 2 170 the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 \ No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Aresidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 24 hours after death. Funeral Director: Af 2 Accident 3 Sulcide 4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

'n State

2

29b. Signature and

31. Date filed (Month, Day, Year)

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's S

Registrar DHMH 17 Rev 7/2009 P0051785

29d. Date signed (Month, Day, Year)

6602 Church

Chestro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 8 2012 Carroll Thomas McClain 10:13 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge 5818 Hudson Wharf Road Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Sept. Day, Year, Months Director 219-14-2622 86 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number death with the 10f. Zip Code 10g. Citizen of What Country? Funeral 5818 Hudson Wharf Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ Black, White, etc. Page 1 and 2 should be filed within 72 hours after of menth and Mental Hygiene. Institute 27 is marked other than "natural", or uny or other traumatic event, the Medical Examiting or other traumatic event, the Medical Examiting. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Year or Dates. white 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) masonry contractor owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll T. McClain Viola Creighton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris McClain wife 5818 Hudson Wharf Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 2/11/12 Cambridge, MD 22. Name and Address of Facility Thomas, Funeral Home P.A. ture of Funeral Service 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between set and Death Immediate Cause (Final Physician/ MELANOMA-Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial-1 the attending physician the dorum th Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) cat has teen signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificat 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural N 5 Pending Investigation
6 Could not be 1 🗌 Yes 2 🗀 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) -9-2012 D39887

Registrar
DHMH 17 Rev 7/2009

30. Name and

David H. Smith

FEB 1 0 2012

31. Date filed (Month, Day, Year)

M.D.

8221 Teal Drive, Ste 302, Easton, MD

21601

mpleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death ZSUA Physician/ Medical institution, give street and number Examiner Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Director 1 M 2 1 F , or items 23a or 28a-f show 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U5 A 6 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter dical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes ? 1 Yes 2 No 3 ₩ Widowed 4 Divorced Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Touse wi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) New Market. PSUNTOI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō Important: If it any injury or o ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State V.M. Church Cometer 4 ☐ Donation 5 ☐ Other (Specify) Reidsbrove 21. Signature of Funeral Service Licensee unera vashington Str eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical I or Attending Physician: The law requires that the death certificate beath or after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy perform death? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number npleted cause of death (Item 23a) (Type 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:35 pm **Physician** Ruth Pusey Muir February 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Princess Anne If Under 1 Year If Under 24 Hrs. Aurora Senior Living of Manokin)omerset If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth July 3,1915 '. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Min 216-12-1907 96 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If which all Examinat must be netitied. 1 ☐Yes 2 No Director MD. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Lemmon Hill Lane 21801 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Postmaster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Pusey Naomi Bozman Pusey 19a Informant's Name/Relationship *(Type. Print)* Charles Muir Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 411, Princess Anne, MD. 21853 20a. Method of Disposition

20a. Method of Disposition

3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Peters U. M. 2/11/2012 Oriole, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD. M00295 21853 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipty, or heart failure. List only one cause on each line. Imme av e Cause (F dise o or condition res ing in death) e Cause (Final **Physician** Due to (or as a consequence of): 24613 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ng physician and as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached for 1 ☐Yes 2X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate rmed? 2/No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

of Vital Division

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State Registrar 29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. USHA NATESAN 31. Date filed (Month, Day, Year)

La Ni

1415 . S. DIVISION ST , SALISBUPY 32. Registrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0051359

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 6:38 P M FEBRUARY 6, GENE KENNETH MINK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death OUEEN ANNE'S GRASONVILLE HEARTLAND HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 X M 2 D F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours 07/07/1930 COUNTRGINIA 81 Yrs **Director** 217-26-4106 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD QUEEN ANNE'S GRASONVILLE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral UNITED STATES 21638 501 PROSPECT BAY DRIVE EAST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1947If Yes, Give
Year or Dates. 1951 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the PUBLIC TRANSPORTATION BUS DRIVER 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည IRENE LAWSON PRESTON MINK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 PROSPECT BAY DRIVE WEST, GRASONVILLE, MD 21638 VALERIE JO HORAN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BROAD CREEK CEMETERY : 02/11/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Failure to Onset and Death Physician/ THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, iner cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam Reus Failure To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical 12 Heiners Sementen with Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerelin Vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👺 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N**o Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARE Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 541

Registrar DHMH 17 Rev 7/2009

State

31 Date filed (Month, Day, Year)

FEB

223 High Street

ime and address of person who completed cause of death (Item 23a) (Type, Print) in Clubble 7n . Mb, 223 High S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles H. Meade February 2012 12:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Annapolis** Examiner 4c. County of Death Genesis Eldercare, Spa Creek Center Anne Arundel Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 412-16-3799 98 Director 1XXM 2 □ F 1913 May 15, Virginia 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director |Maryland Anne Arundel Annapolis 1XXYes 2 ☐ No 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 1350 Blackwalnut Court 21403 U.S.A. or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married XX Yes Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White "natural", 3 ₩Widowed 4 □ Divorced Year or Dates. 1939-66 Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Civilian Employee U.S. Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles A. Meade Cosby E. Smith of Health and Me of Health and Me fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Demma/stepdaughter 1350 Blackwalnut Court Annapolis, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 2/11/2012 Annapolis, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice se 22. Name and Address of Facility John M. Taylor Funeral Home Todd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pneumonia Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery been signed by the atter should be detached for in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performed 2XXN 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 XX Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XXIatura 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier KX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 06-2011

State

2108 DiDonato Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Sprouse

FEB 0 9 2012

D32036

Chester, Maryland

February 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month tom 6:03 PM Tuk A Ka 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner County Howard Howard Genera Hospita. Columbia 8. Date of Birth
(Month, Day, Year)
June 26, 1927 Social Security Number If Under 1 Year If Under 24 Hr **Funeral** 9. Birthplace (State or Foreign Months 577-88-3063 Country) China Director 1 □ M 2 🙀 F 84 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Howard Dayton 1 Yes 2 No Page 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4838 Ten Oaks Road 21036 China 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give Asian 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I marked o ဂ Kwok Wah Lam Suk Ying Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Man Che Ma / Son 6441 Quiet Night Ride, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth January 30 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State George Washington Cemetery 2012 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ myocardial disease or condition Medical resulting in death) **Examiner** Coronary Securities like a relations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Unknown signed by the at id be detached for 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ aneurysm 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 Yes Yes

The law requires that the death certificate be Division of Vital Records, To the Hospital or Attending Physician; "within 24 hours after death.

To the Funeral Director: After this certification of the funeral Director of the funeral director, is simple the funeral director. Be မ Certificate:

2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗆 🗖 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

V42892

Lane

Columbia

29d. Date signed (Month, Day, Year) 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chuidian 31. Date filed (Month, Day, Year)

(Check

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Cedar

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 2 U 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25, 2012 11:45 A M Karl D. Mullen Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Days Hours (Month, Day, Year) 579-48-4478 78 **Director** 1 🖾 M 2 🗆 F 1933 Sep. 29, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Silver Spring 28a-f Maryland Montgomery 1 🗌 Yes 2 🏝 No 1/25/2012 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ ms 23a or must be r Funeral 20906 15310 Beaverbrook Court 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1953 Black, White, etc ь ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ KNo Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur rumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Contractor Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Annabelle Fischer Dewitt C. Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Thomas G. Mullen / Son 23919 Log House Road, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 31 φ 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once, Šilver Spring, MD Gate of Heaven Cemetery 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis Address of Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Arr hy Thinia disease or condition resulting in death) minutes Medical Due to (or as a consi quence of) Examiner massive Cardiac Sequentially list conditions, if any, leading to an insulate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se a consequence of) vascular ronic and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 d IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 Yes 2 L 9 Unknown detached Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending the 2 Accident Investigation 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1541 72607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Car Dr Chen mi 31. Date filed (Month, Day, Year) State JAN 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1,23a, pt. II,29d, per physical 2-28 12 state of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frances Physician/ canees Margaret Malec \mathbf{p}^{M} February 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing & Rehab. Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours (Month, Dav. Year) 334-10-1274 Director 1 □ M 2 🔀 F 97 April 11, 1914 Indiana or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code ems 23a or must be r 10g. Citizen of What Country? with Funeral 8903 Walden Road 20901 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Giv 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 A No Specify. "natural", 3X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Hair & Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Julian Endres permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Kathryn Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Carter/Daughter-in-law 1210 Snowden Place, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 $\stackrel{\textstyle \mbox{\fontfamily{\fon$ 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licenses Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Dementia Sepsis Medical resulting in death) Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or men) Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Multiple Sclerosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an has e 2 autopsy perform page certificate Yes 2X No 1 Yes 2 No i 24 hours after ασαν... • Funeral Director: After this certinα nletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🔀 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier **с** ф тр е е е е within 24 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69800 February 2/27/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Rockville, MD 20850

State

Registrar

Tao Yu, MD

31. Date filed (Month, Day, Year)

FEB 0 7

2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05712

			State Registrar		Cen	tificate of E	Death	R	leg. No.			
S.			Decedent's Name (First, Middle, Last)					2. Date of Deat		Vear	3. Time of	Death
	Physicia Medic		Georgia Mandris Nich	ols				Februar	cy [□] 3, 20	12	1:45	Рм
Cion	Examin		4a. Facility Name (if not institution, give street and			4b. City, Town, or		th	4c. County		4	
J.			265 West Pasadena Roa			Millers			Anne A			
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 5	7. Age (In yrs. last birt	thday) Yrs.	Months Days	If Under 24 Hr. Hours Mir			9. Birthpi Count Mary.	lace (State or Land	Foreign
	nd at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Loc	ation				10	0d. Inside Cit	y Limits
	arylar a-f sl fied	Director	Maryland Anne Arundel			Millers	ille				1 🗆 Yes	2 X No
	or 28 or 28 or noti	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	try?	
	with t	Funeral	265 West Pasadena Ro	ad			21	108	USA		L	
	tems er mi	ᇤ		Decedent Ever in U.S.	13. V	as Decedent of H	ispanic Origin? (S	Specify Yes or No-		e - America k, White, e		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 If Yes	Yes 2 XNo s, Give or Dates.		Yes 2 XNo			Specify:			
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5	d wit Hygie ther int, th	Be C	17. Father's Name (First, Middle, Last)		Kes	Laurant (ame (First, Middle, I				
lanc	be filed lental Hy- rked oth ic event	To E	Nicholas J. Mandris					n Aposto				
Mary	should be file n and Mental 7 is marked c raumatic eve	1	19a. Informant's Name/Relationship (Type, Print)					oral Route Number Shington			Code)	
e,	and 2 s Health tem 27		Nick Apostol - Nephev	20b. Place o	of Dispos	sition (Name of		Date	20c. Location -		wn, State	
mor	Page 1 nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place rios Ceme		6/2012	Annapo	olis,	MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.	j	21. Signature of Funeral Service Licensee	Police I				John M. Ta ester St				
			23a. Part 1. Enter the disease, or complications	that caused the death. Do							Approximate Interval Bety	9
princ.	Physician/		shock, or heart failure. List only one cause Immediate Cause (Final		han	no toma		I of	.)	,	Onset and D	Death
	Medical	1	disease or condition resulting in death)	ue to (or as a consequence		10 / 0	٦	10	- 0			
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8760	physi physi the l	Medical	d				V	1/.				
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	s, outcome of pregnancy Live Birth 2 ☐ Fetal deat Pregnant at time of death Unknown		Ectopic pregnan Other (specify)	су			ite of delive		⁄ear
P.O.	hat the		Part II. Other significant conditions contributin	g to death but not resulting	in the u	nderlying cause gi	iven in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of d	eath?
5, 1	ires t sign	ed by	Derkinsons Di	scere fa	ila	re to	Huriv	ا ⊒	Yes 2 No	3 🗌 Prol	bably 4 🗌	Unknown
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al F	ician: The certificate rector, paç	Be C	25. Was case referred to medical			26. F	lace of Death (C					
Ζij	ys di 5	일	examiner? 1) Yes 2 \(\subseteq \text{No} \) Hospital:	1 Inpatient 2 ER/O	Outpatier	nt 3 DOA Oth	ner: 4 🗌 Nursing	Home 5 Resid	lence 6 Oth	er (Specify	/)	
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Division	lor At after o Direct d in by	Certificate:	4 Homicide determined	Place of Injury - At home, for building, etc. (Specify) esidence	arm, str	eet, ractory, office		28f. Location (S City or Tow Millers	ville,	$MD^{W}21$	asader 108	a Rd
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To	the best of my knowledge	or inves	tigation, in my opin	ion, death occurre	e, and due to the ca	ause(s) and man	ner as stat	ed. use(s) and ma	
	thin 2.	Me	only one) 3 Certifying Nurse Practi	tiener: To the best of my kno	owledge	, death occurred at 29c. Licens	the time, date an	d place, and due to t	he cause(s) and r 29d. Date signe	manner as	stated.	
	o Nit		· C/1/4	in)		T)418/	6	2/3	/20	12	
	,		30. Name and address of person who complete	d cause of death (Item 23a)	(Type, F	Solmo	us Is!		Anny	re/is	MD	2 140/
	Sta		31. Date filed (Month, Day, Year) FEB 0 8 2012	32. Registrar's Signature	1 2	ball			-///	,		
	Registr	ar	I ED O COL	DETERMINE PO	· 24	-						

Amend #8 per Fh State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 1 - For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARY GRACE VAN NEST Physician/ 31 11:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1306 ANGLESEY DRIVE DAVIDSONVILLE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min (Month, Day, Year, Months NEW JERSEY Director 147-34-5783 69 1 □ M 2X F Vrs 9/15/1942 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Maryland Examiner must be notified at Director 1 Yes 2X No MD ANNE ARUNDEL DAVIDSONVILLE 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō 23a Funeral 1306 ANGLESEY DRIVE 21035 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. o 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HEALTH CARE 12 MEDICAL RECORD ADMINISTRATOR event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname)
GRACE D. QUILGAN permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is many injury or other. filed 17. Father's Name (First, Middle, Last) 2 WALTER J. PALTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 ANGLESEY DRIVE DAVIDSONVILLE, MD 21035 RONALD VAN NEST/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
ST. BERNARD CEMETERY 2/7/2012 BRIDGEWATER N.J. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22 Name and Address of Facility LASTING TRIBUTES BY FELLOWS ARE, P.A. 814 BESTGATE ROAD ANNAPOLIS MD 21401 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Approximate Interval Between Onset and Death CANA Immediate Cause (Final Physician/ SMALL CELL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician; The law requires within 24 hours after death.

To the Funeral Director After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 \square Pending Investigation the Accident 2 Accident
3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 2012 0064852 31 MEDICAL ONLOCK 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS RAVIN GARG. 31. Date filed (Month, Day, Yea 32. Registrar's Signature State 3 2012 ack Registrar

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1 and if Heal item other		Dolores 1 20a. Method of Dispo		Wife	20b	. Place of [Disposition (N	ame of			anover,		ocation - City	or Tov	vn, State	_
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2	Medical Exa		is of examina	tion and/or i	investigation, i	n my opinio	n, death oc	curred at	the time, date a	nd place	e, and due to tl	ne caus	se(s) and manner state	ed
To the within To the compl	Σ	only one) 3 l 29b. Signature and ti	-//	se Practitioner	: To the best o	T MY KNOW!		9c. License		te and pia			e(s) and manne ate signed (Mo			_
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mark!	\$ <u>-</u>		Montgomery Hospice-Cas 5. Social Security Number 6. Sex	ey House 7. Age (In yrs. last birtho	Rockv	IIIe If Under 24 Hrs.	8. Date of Birt		gomery 9. Birthplace (State or Foreign					
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	MC T		Usual Residence of Decedent				April 1	3, 19/3		xas				
	aryland a-f sho fied at	Director	10a. State 10b. County MD Montgomery	10c. City, Town o	lver Spring					0d. Inside City 1 Yes 2				
	he Ma or 28a e notii		10e. Street and Number		10g. Citizen of \	What Coun								
	with 1 s 23a ust b	418 Hillsboro Drive 20902 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-												
	death item: nerm													
38	al", or	d by	White											
2	hours 'natur	Completed	15. Decedent's Education (Specify only highest grade completed	16a. D	Decedent's Usual Occupa		na	16b. Kind of B	usiness/Ind	dustry				
21215-0036	hin 72 ne. than ' te Me	omi	(Specify only highest grade completed) College (1-4 or 5+) College (1-4 or 5+)											
р О	ed wil Hygie other ent, tt	Be (17. Father's Name (First, Middle, Last)	Ji AS	trophysicis 	18. Mother's Name	e (First, Middle,	Self- Maiden Sumame		эуеа				
<u>lan</u>	should be filed wand Mental Hyg 7 is marked oth raumatic event;	2	J. Maurice Mahan			Pat Rug			,					
lan	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	- 1	Mailing Address (Street a									
ه ک	ge 1 and 2 st of Health If item 27 or other tr		Curt Stanley Niebur/Hus 20a. Method of Disposition		8 Hillsboro									
nor	Page 1 anent of Hant of Hant: If ite		1 🗌 Burial 2 🛛 Cremation 3 🗎 Removal from	State cemetery,	Disposition (Name of crematory or other place	Fel	Date 6,	20c. Location	-					
Baltimore, Maryland	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	метгоро	litan Crema 22. Name and Addres		2012	Alexand						
m	Per Purp any		Joseph P. Joto	mo 1503	22. Name and Addres Francis J. 500 Univer	sity Blvo	Funeral	Home I Silver S	nc. pring	z, MD 2	0901			
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea	caused the death. Do not ach line.	t enter the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate Interval Between				
إلمست	Physician/ Medical		requiting in dooth)	static Brea					-	Onset and De	ath			
	Examiner		Due to (or as a consequence of):											
٤.		iner	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of)	:									
	cuted	Examiner	Cause (Disease or injury that initiated events c.											
_	cate be executed physician and the burial transit		resulting in death) Last Due to	(or as a consequence of)										
200	icate t g phys	fedical	d											
89 x	ending r use	an/N	23b, was decedent pregnant	tcome of pregnancy Birth 2 Fetal death	3 Ectopic pregnanc	V		- 1	te of delive	•				
Bo	e death the att hed fo	Physician/M		nant at time of death	5 Other (specify)			Mo	nth	Day Yea	ar			
Ö	hat the ed by detac	y Ph	Part II. Other significant conditions contributing to c	leath but not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of dea	ath?			
S,	uires t n sign uld be	ed by					1 🗆 1	res 2 🖺 No	3 🗆 Prot	oably 4 🗆 Ur	nknown			
Sor	aw req as bee 2 sho	plet					24a. Was a		Were autop	osy findings ava mpletion of cau	ailable use of			
Be	The ka	Completed						rmed?	death? 1 🗌 Yes					
ţa	ician: certific rector	Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2\(\begin{array}{c} \text{No} \\ \end{array} \) Hospital:		_ Othe	ce of Death (Check		Но	spic	<u> </u>				
<u></u>	Phys er this eral di	e: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Outp of injury 28b. Tin	ne of 28c. Injury	4 L Nursing Ho		ence 62 Oth						
ono	anding ath. rr. Afte	ficat	2 Accident Investigation	th, Day, Year) inju		Yes 2 No								
VISI	or Atter fter de lirecto in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build	e of Injury - At home, farming, etc. (Specify)	n, street, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number	5			
Ō	pital o		29a. Certifier 1 Certifying Physician: To the b	nest of my knowledge de	eath occurred at the time	date and place a	nd due to the ca	use(s) and man	ner as state	ad a				
	ie Hos n 24 hi ie Fun oletely	Medical	(Check 2 Medical Examiner: On the ba	sis of examination and/or i	nvestigation, in my opinio	n, death occurred at	the time, date a	nd place, and du	e to the cau	use(s) and mann	ner stated.			
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and To the Funeral director, page 2 should be detached for use as the burial transit		29b. Signature and title of certifier	_	29c. License			29d. Date signe						
	"au	20.3	Micole Christer			20698	I	Tebruary	6, 2	2012				
			30. Name and address of person who completed cau Nicole Christensen, CRN		pe, Print) # ccard Drive	100 Rockvil	lle. MD	20850			i			
	Sta	e		Pogiotror's Signature		, ROCKVI.	LIC9 III	20000						
	Registra	ar	FEB 0 / 2012 Cent	un B. A	arlas									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician/ Month Year Dorothy Ann 01ek 2°51 p M 2012 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours July 31, 1926 Pennsylvania 85 Director 189-20-6807 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director Maryland Prince George's Berwyn Heights 1 ☐ Yes 2 🙀 No permit. Page 1 and 2 should be filed within 72 hours after death with the happerdment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and injury or other traumatic event, the Medical Examiner must be not one. 40e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6109 Ruatan Street 20740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Callege (1-4 or 5+) House wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eschenbaugh Kenneth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 Cari Court, Huntingtown, MD Deborah Vass- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. Date ☐ Burial 2XXXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee Crematory 2012 Clinton, MD 21. Signature of Funeral Service Licensee Amanda M 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Ergler art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Atherosclerotic Cardio Vascular dinas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Stage 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X N CONGES HIVE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier -50653 on 30. Name and address of person who completed cause of death (item 23a) (Type, Print) SURANA GYAN 5651-Deale church 700 Rd. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alvin Junior PHELPS Physician/ Phruan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, g. Birthplace (State or Foreign **Funeral** Davs Hours 169-16-6267 Director 1 🖾 M 2 🗆 F 89 Pennsylvania June 11,1922 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location aţ 10a. State Director Examiner must be notified Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò 21740 23a U.S.A. 68 Redwood Drive items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1942 "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify. 3 Widowed 4 Divorced 1946 Completed the Medical Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic even." (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) land Clearing owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ Lily Weber Charles Phelps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth M. Phelps - wife 68 Redwood Drive, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State February, 14 Hagerstown, Maryland 4 Donation 5 Other (Specify) Hagerstown Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 1 askel 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final corebrovasaular Hemorrhagic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a son sequence of it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed after death. as the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy the Funeral Director: After this certificate has appletely filled in by the funeral director, page 2: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖳 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No atural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital To the Hospital of within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State

3 29b. Signature and title of certifier

31. Date filed (Month

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

H0061117

renins redical

29d. Date signed (Month, Day, Year)

William Gunton Plavcan, Jr.

2	0	And in case of Females, Spinster,	2	0	5	7	- Contracted	8
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		Registrar Certifica	te oi	Deain					Reg. No.			
Physici ndical Exami	ner	1. Decedent's Name (First, Middle,Last) William Gunton Plavcan, Jr.						Date of De Month February	Day 10, 20			3. Time of Death 1657 hrs
		Facility Name (if not institution, give street and number) 18603 Preston Road	4	b. City, Tow Hagerst		ocation of	Death		- 1	County of /ashingt		
Funeral Director		5. Social Security Number $212 - 84 - 6879 \qquad \begin{array}{c} \text{6. Sex} \\ \text{1} \boxed{X} \text{M} \text{2} \boxed{\text{F}} \end{array} \qquad \begin{array}{c} \text{7. Age (In yrs. last birth} \\ \text{52} \end{array}$	day) Yrs.		Year Days	If Under Hours	24Hrs. Min.	8. Date of B Aug • 7	,1959) 9	9. Birth Foreign Cour	place (State or Pennsylvan try)
Maryland 28a-f show any d_at_once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Washinton County 10c. Street and Number		1 10f. Zip Co					_	en of Wha		Od. Inside City Limits 1 Yes 2 No y?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	18603 Preston Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of 15 Person Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Yo	s Decedent ces, specify C	of Hispa Suban, I	Mexican, I			lo-	S.A. 14. Race - White, Specify:		nn Indian, Black,
0036 within 72 hours af jene. ner than "natural Medical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Add	uring mo	t's Usual Doost of workin	g life. D ire	ob NOT u	se retire	rk done d) First, Middle	Nur Man	ind of Busi sing ageme	Hom	e
21215-(Muld be filed Mental Hygi marked oth	BB	17. Father's Name (First, Middle, Last) William Gunton Plavcan, 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing	Address (Caro.	l Co	oper			State, 2	Zip Code)
ore, MD es 1 and 2 sho of Health and I item 27 is her traumati		20a. Method of Disposition 20b. Place of	Dispos	ner place)	of ceme	etery,		Date	20c. L	ocation - 0	City or T	own, State
Baltime permit. Pag. Department Important: injury or ot		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22. N	lame and Ad	dress o	of Facility	Γοι	ıglas	A. F	iery	Fune	eral Home MD 21742
Physician Wedical Examiner		25a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):	enter th	ne mode of o	lying, st	uch as ca	rdiac or r	espiratory a	rrest, sho	ck, or hear	t	Approximate Interval Between Onset and Death
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):										
O, e be execut rsician and burial - trai	n/Medical	d. UNPENDED AMENDED							224	I. Date of d	eliven	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	=	tal death her <i>(Specif</i> y	3 [Ectopic	pregnan	су		Month	Da	y Year
ires that the signed by the detached	12	Part II. Other significant conditions contributing to death but not resulting	in the u	inderlying ca	iuse giv	en in Par	t I.	1 🗌 Y	es 2	No 3	Proba	
Division of Vital Records, P.O ral or Attending Physician: The law requires that the stafter death. In all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed by						_	per	s an opsy formed? 2 No	pri de		psy findings available mpletion of cause of
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Ou	tpatient	C7		of Death (nlyone) Home 5	Resider	nce 6 🗸	Other:	Scene
on of V ending Phy ath. vr: After th'	tion: To	27. Manner of Death 1 Natural 5 Pending Polynomb. 28a. Date of Injury Polynomb. Day, Year) FOUND: Sep 10, 2012	ime of I	njury 280	. Injury	at Work?	2	8d. Describe ubject ha	e how inju	гу оссите		
Division of You the Hospital or Attending Phewithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	28e. Place of Injury - At home, far (Specify) Single Family Homicide	m, stree				1:	or Town, 8603 Prest	State) on Road	I, Hagers	stown, i	
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) 2 Medicel Examiner: Do the best of my knowledge, dear one) 2 Medicel Examiner: Do the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	th occur vestigat	tion, in my op	oinion, o	e and place death occ number	ce, and d urred at	ue to the ca the time, dat	te and pla	ce, and du	e to the	h, Day, Year)
		30 Name and address of person who completed cause of death (Item 23a)	1		D.C.M				Ш	ruary 11	, 2012	2
W-6		Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Date) 2 32. Refistrar's Signature	-	W. Baltin	ore S	Street, E	Baltimo	ore, MD 2	1223			· · · · · · · · · · · · · · · · · · ·
S Regis	tate trar		A	Co. Asia					DOME	:		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf 9925 3-23-12 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year ZOLZ Month February Patricia Physician/ 7:45 AM Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Northwest Hospital 5. Social Security **7.95**2 245 82 525 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Country 245 60 **Director** 1 □ M 2 🏻 F Yrs. 05/02/1951 NC items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director Baltimore 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21229 4783 Melbourne Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No à 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Hospital Admin. Asst. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Gladys Taylor Obey Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4783 Melbourne Rd.Baltimore, MD 21229 Chrislyn P.Parker/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Park2/11/2012 Baltimore, MD Memorial reene Funeral Home 911stwfnfigld,NC27823 Signature of Funeral Service Licens 22. Name and Address of Facility Vaug Kimberly Libert Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Ph_sician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death be detached signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has page 2 certificate Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence inputient Hospice P Hospita 2 Ly No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 \square Pending within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only dr 29b. Signati and title 29c. License number 29d. Date signed (Month, Day, Year) 42012 DOOS333 Ebruary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 203 Bultimore, Md 21204 Sean 28355mi remie 31. Date filed (Month, Day, Year) FEB 0 9 32. Registrar's Signature State 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4	For State		State	e of Ma	ıryland		rtmen <i>tificate</i>			and M	1ental Hy	_	201	2	0572	Ω
				Registrar 1. Decedent's Name	e (First Middle	l ast)			Ceri	incate	; OI L	eatti		2. Date of De	Reg. N	10. <u>C</u> U 1	Sime.		
		siciar		Louise	, ,	,	וו							Month		Day 201	ear	3. Time of Death 10:08P	
		/ledica amine	_	4a. Facility Name (if						4b. City,	Town, or	Location of	of Death			c. County of		20.001	
)			Atlanti	c Gene	ral Ho	ospit	cal		Вє	rli	n				Worce		er	
	Fun			5. Social Security N	umber (6. Sex 1 ☐ M 2基	7. Age	(In yrs. las	t birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th	9	Birthp	lace (State or Forei	ign
	Dire	ctor		578-36-		1 L M 241		80	Yrs.	WIGHTIG	- Juju	riodio		4 Mpnth, Pa	2'9'3'.	1 W	ash	igton D	C_
	pu how	ta	- 1	Usual Residence of 10a. State	10b. County			10c. City,	Town or Loc	ation		-					1	0d. Inside City Limi	its
	aryla a-fs	ified	Director	MD	Worce	ster		0c	ean P	ines	5							1 ☐ Yes 2X☐	
	the M	e not		10e. Street and Nun						10f. Zip			_		10g. C	Citizen of Wh	at Cour	try?	
	with s 23a	nst b	Funeral	60 Ocea	n Park	way					218	11				USA			
	leath items	er m	ᇎ	11. Marital Status		Armed	ecedent Ev		13. W	as Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -			
98	after of ", or	camir	<u></u>	1 Never Marri		ed 1 🗆 Y	′es 2.2Xin	No				Specify:		riloan, cto.)		Black, Specify:			
Ş	ours a	<u>명</u>	Completed	3 Uidowed	4 ☐ Divorced 15. Decedent	Year o	r Dates.		16a. Decede									nite	
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2 6	within giene.	the the		Elementary/Seco	onday (0-12)	College 1	e (1-4 or 5+	-)	Secr							Educa	tic	on	
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$\frac{1}{2}$ β'	ld be Menta	atic e	잍	William	Norma	n						Myrt	le	Davis					
ス <i>(辿 ふえの8</i> Marvland 21215-0036	shou and is m	Lagran Lagran		19a. Informant's Na						_				l Route Numbe				,	
	and 2 Health	thert	J	Jerry P		/ hus	band	Look Di-				ırkwa		Ocean					
$\mathcal{Z}_{\mathcal{Z}}$	ge 1 and int of h	0.0		1 ☐ Burial 2 Ì	XCremation :		rom State	1 cer	netery, crem	atory or of	her place	e)) / 2012		Location - Ci	-		
ス/08/2018 Baltimore M	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	in jury	-	4 ☐ Donation 21. Signature of Fur	5 LJ Other (Sp			LTT				:		rbage					
9 18 18	Depart	any ir		1/1	The /c	Dule	ef-						-	Berl					
				23a. Part 1. Enter f	isease, or o	omplications th ly one cause or	na caused t n ach line.	the death.	Do not enter	the mode	of dying	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between	
700	Physic			Immediate Cause (disease or conditio	Final n	_ a		SP	PSIS	\$								Onset and Death	
7	Med Exam			resulting in death)	- (Due	to (or as a	conseque	ce of):										
3			ا <u>ب</u>	Sequentially list con if any, leading to im	nditions,	b. — Due	to (or as a	conseque	nce of):								+		
6	ted .	insit.	Examine	cause. Enter Under Cause (Disease of	lying		,		· ·								4		
13/	ate be executed	ral-tra	<u> </u>	that initiated events resulting in death) I	_ast	C. Due	to (or as a	conseque	nce of):								\top		
<i>>></i>	te be	ing et :	dical			d											\perp		
200	certificate	ast	ğ	F FEMALE:															
18 Box 6	th cel	or use	ian/	23b. Was decedent in the past 12 r	nonths?		ive Birth 2	l 🗌 Fetal d	death 3 🗌	Ectopic p	regnancy	/				23d. Date of Month		ry Day Year	
28	that the death ned by the atte	ped .	ysic	1 Yes 2 19 9 Unknown	Ñ No		regnant at i Inknown	time of dea	ath 5 □	Other (sp	ecity)					Mont		Day real	
\sim $^{\circ}$	nat th	detac	=	Part II. Other signif	icant condition	s contributing t	to death but	t not result	ting in the un	derlying c	ause give	en in Part I	l.	23e. Did to	obacco	use contribu	te to th	e cause of death?	
	uires t sign	90 E	Completed by Physician/Me											1 🗆	Yes 2	2 🗆 No 3	☐ Prob	ably 4 Unknow	wn
Course N. of Vital Becords.	v requ	nous												24a. Was		24b. Wei	e autor	sy findings availabl	le
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ouise f Vital Be	hysic nis ce	direc	္ [1 🗆 Yes 2 🗷	Î No				R/Outpatient	3 □ DC	A Other	r: 4 □ Nu	rsing Ho	me 5 🗆 Resid	dence	6 Other (Specify		_1
	ing P	nnera	Certificate:	27. Manner of Death 1	n 5 □ Pending	28a. D:	ate of injury <i>Ionth, Day,</i>	Year)	8b. Time of injury		c. Injury work?	?	- 1	28d. Describe h	now inju	ry occurred			
/\ is	ttend death tor: /	the !	1 €	2 Accident 3 Suicide	Investiga 6 Could no	ot be	and of laise	. At ham	e, farm, stree	M factory		Yes 2 🗆	\rightarrow	0011		1.81 6		Sanda Manakan	
Je//, /	after Direc	ت و ا	ခ်	4 Homicide	determin		uilding, etc.		e, iaiii, sire	et, lactory	Onice			City or Tou			r Hurai	Route Number,	
Dowell,	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending of		Medical	29a. Certifier 1	Certifying F	hysician: To th	ne best of m	ny knowled	dge, death o	ccured at t	he time,	date and p	olace, and	d due to the ca	use(s) a	and manner a	s state	d.	
1	the He	plete			Certifying N													se(s) and manner stated.	ated.
	To t	COL		29b. Signature and t	title of certifier						License		0		29d. Da	ate signed ($^{\Lambda}$	1onth, E	Jay, Year)	
			-	MAL	1	/					000	54/2			X	111201	_		
	Í	OF	_	30. Name and address		o completed c	ause of dea	ath (Item 2	3a) (Type, Pr	n've	Ben	11'4	MD	2181	1.				
	Rec	State		31. Date filed (Month	r, Day, Year) FEB 0 9		2. Registrar	's Signatur	h be	erka	,								
							The same of the sa	^	17				_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#17 per FH 1 - State Registrar 2/6/2012 AACO HEALTH DEPT. CMH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 1, 2012 Vasilea Alvanos Panos 7:25 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Annapolis 4 6 1 1018 Sandpiper Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Min (Month, Day, Year) 85 Director 219-16-1858 1 🗆 M 2 🗗 F 6/29/1926 Greece Usual Residence of Decede show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director Annapolis 1 Yes 2XNo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 1018 Sandpiper Lane death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, ral", or iter Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: "natural", 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the C1erk State of Maryland Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Theano Mamoulides Constaninos Alvanos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Golden Eye Ct, Arnold, MD 21012 Michael Panos - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Demetrios Cemetery 2/4/2012 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Mydin 1. Weller 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final rement A Physician/ Mer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** perten On Sequentially list conditions ii any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transit and as a consequence of resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year igned by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\text{Nursing Home } 6 \text{Residence } 6 \(\text{Other (Specify)} \) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: At the Accident Investigation 3 Suicide
4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature Ad title of certifie 29c. License number 29d. Date sibned (Menth. Day, Year)

State Registrar gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

21401

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Chata at Mandanal / Danachmant at Healt		s Are Legibl	e.
State of Maryland / Department of Healt 1 - State	-	001	0 05700
Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
Physician/ Medical Peggy Frances Pixley	Februa	ary 6, 2012	5:21 p M
4b. City, Town, or Location 4c. Facility Name (if not institution, give street and number) 4c. Facility Name (if not institution, give street and number) 4c. City, Town, or Location 4c.		4c. County of De Worces	
	der 24 Hrs. 8. Date of Bi	rth 9.1	Birthplace (State or Foreign
Director 343 - 38 - 8 796 1 □ M 2 1 F 73 Yrs.	10/05/		country) st Virginia
To State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Pocomoke City 10e. Street and Number 10f. Zin Code			1 XYes 2 ☐ No
g 5 5 0 10e. Street and Number 10f. Zip Code 205 Tenth Street 21851		10g. Citizen of What USA	Country?
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	ican, Puerto Rican, etc.)		
3 ☐ Widowed 4 X Divorced If Yes, Give 1 ☐ Yes 2 X No Spec	cify:	Specify:	White
3 Widowed 4 K Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Secondary (0-12) College (1-4 or 5+) Library of Congresian Congresia Congresia Congresia Congresia Congresia Congresia Congre	most of working	16b. Kind of Busine	ss/Industry
Elementary/Secondary (0-12) College (1-4 or 5+) Library of Congre	ess	U.S. Gove	ernment
To have been a second of the s	lother's Name (First, Middle Jean Smith	, Maiden Surname)	
19a. Informant's Name/Relationship (Type, Print) Marc Pixley/son 19b. Mailing Address (Street and Nur 204 Tenth St.	mber or Rural Route Numb , Pocomoke Ci	er, City or Town, State, Lty, MD 218	Zip Code) 351
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	2/8/2012	20c. Location - City Salisbur	
21. Signature of Functal Septite Licensee 21. Signature of Functal Septite Licensee 21. Signature of Functal Septite Licensee 107 Vine St.			Association 351
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician/ Medical Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) a. Aleuvo en a consequence of the condition resulting in death)	E (ARC	LINON	Onset and Death
Examiner			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
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d of the past 12 months? Size Continue			
de de de de de de de de de de de de de d		23d. Date of Month	delivery Day Year
Far ii. Other significant conditions contributing to death but not resulting in the orderlying cause given in P			e to the cause of death? Probably 4 Unknown
The law requires to the la	24a. Was auto perf	ppsy prior to death	
LE tra de de la companya de la compa	1	2 No 1 .	Yes 2 □ No
26. Place of E 26. Place of E 27. Manner of Death 28. Date of injury 28. Injury at work? 28. Injury at work? 28. Injury at work? 28. Injury at work?	Nursing Home 5 Res		pecify) Son's
28a. Date of injury 28b. Time of linjury 28b. Injury at work? 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		how injury occurred	
호 분 품 드 8 Building, etc. (Specify)	City or To		
Dullding, etc. (Specify) 2 9a. Certifier (Check only one) 2 9a. Certifying Physician: To the best of my knowledge, death occurred at the time, date a conclusion of the control of the c	th occurred at the time, date	and place, and due to th	ne cause(s) and manner stated.
후 일 후 only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time,	er	29d. Date signed (Mo	
D29:	283		7-2012
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, 29b. Signature and title of certifer 29b. Signature and title of certifer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timmy D. Taylor 100 E. Carroll 5t. Salis State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 9 2012	283		7-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Maryland / De	partment of F ertificate of L			2012	05723
			Registrar 1. Decedent's Name (First, Middle, L	ast)	C	erinicate of L	Jealli	Reg. 2. Date of Death	No. 4 U 1 4	7 0 7 4 0
	Physicia		Ruth	Ann	Prien			Month February	Day Year 4. 2012	3. Time of Death 3:55 P. M
	Medic Examin		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Death	repluary	4c. County of Death	
	,		19008 Staleybrid	ge Road		German	ntown		Montgo	mery
	Funeral				7. Age (In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Cou	nplace (State or Foreign ntry)
ě	Director		087-26-9754 Usual Residence of Decedent	1 □ M 2 🕱 F	76 Yrs.			April 27,	1935 New	York
	and show	tor	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl 28a-f otified	Director	Maryland Montgo	mery	German	itown				1 🗌 Yes 2 🕱 No
	e flied within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	al D	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	th wit	Funeral	19008 Staleybrid			2087			United St	
	r dea	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed For	rces?	 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (Spe ın, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
980	s afte ral", (Exan		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	re l	1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	ite
2-0	hour 'natu	Completed	15. Decedent's (Specify only highest		16a. Dec	cedent's Usual Occup	ation	ing 16k	o. Kind of Business/I	
2	nin 72 ne. than '	omo	Elementary/Secondary (0-12)	College (1-	-4 or 5+) life.	DO NOT use retired)	uring most or work			
7	d witi	Be C	17. Father's Name (First, Middle, Las	4	R	ealtor			Real Esta	te
Maryland 21215-0036	be filed vental Hygrades rked oth	To E	Walter	•	Bishop		18. Mother's Nam	e (First, Middle, Maid Ruth		
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	2 ± 2 ±	П	Michael W. Prie		T	8 Staleyb:		·	•	
altimore,	e 1 and t of Hea If item or other		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place			Location - City or T	
Ē	Page 'nent o ant; If ury or		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	.itan_Crem		2012 A	lexandria	, Virginia
alti	permit. Page Department Important; I any injury or once.	-	21. Somethire of Funeral Service Lice	ense		22. Name and Addres				, , , , , , , , , , , , , , , , , , , ,
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List only			nter the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
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-	Medical Examiner		resulting in death)	Due to ((or as a consequence of):					
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to ((or as a consequence of):				_	
	dust ted	Examiner	Cause (Disease or injury		(
	re be executed lysician and re burial transi	EX	that initiated events resulting in death) Last	Due to (c	(or as a consequence of):					
09	re be nysicia ne bur	dical		d						
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial transit	Physician/Med	IF FEMALE:							
Box 687	th cel	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live E		Ectopic pregnanc	ÿ		23d. Date of deliver Month	very Day Year
B	e dea the a	ysic	1 Yes 2 X No	4 L Pregr		Other (specify)			WORTH	Day Teal
P.O.	hat th ed by detac		Part II. Other significant conditions	contributing to de	eath but not resulting in the	e underlying cause giv	en in Part I.	23e. Did tobaco	co use contribute to t	the cause of death?
S,	uires t sign Ild be	d by	Secondary Malign	nant Neop	plasm of the	Lung and	the Liver	1 ☐ Yes	2 No 3 Pro	bably 4 🖾 Unknown
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a	ysician: The law Is certificate has t	Bec	25. Was case referred to medical examiner?			26. Pla	ace of Death (Check		NO TES	2 1110
Ĭ		욘	1 Yes 2 X No	Hospital:	Inpatient 2 ER/Outpat	ient 3 DOA Othe	er: 4 D Nursing Ho	me 5 🗷 Residence	6 Other (Specif	y)
1 0	ing P	ate;	27. Manner of Death 1 X Natural 5 Pending	28a. Date of (Monti	of injury 28b. Time th, Day, Year) injury	work	?	28d. Describe how in	jury occurred	
0	Attending Physician: or death. ector: After this certific by the funeral director.	Certificate;	2 Accident Investigat 3 Suicide 6 Could no	the l	of lainer Of house forms		Yes 2 □ No			
Division of Vital Records,	l or Atten after deat Director: I in by the	Cer	4 Homicide determine		of Injury - At home, farm, s ng, etc. (Specify)	street, ractory, onice		28f. Location (Street City or Town, St		il Houte Number,
	To the Hospital or Attending Phy, within 24 hours after death. To the Funeral Director: After this ampletely filled in by the funeral Director.	ical	29a. Certifier 1 X Certifying P	hysician: To the be	est of my knowledge, deat	h occurred at the time	e, date and place, ar	nd due to the cause(s	s) and manner as sta	ted.
	n 24 i	Medica	(Check 2 Medical Exa	ıminer: On the basi	sis of examination and/or inv To the best of my knowled	estigation, in my opinic	on, death occurred at	the time, date and pla	ace, and due to the ca	ause(s) and manner stated.
	To the Hospital or I within 24 hours after To the Funeral Dire		29b. Signature and title of certifier			29c. License			Date signed (Month,	Day, Year)
	(b)		Forde Sta	renea	<u>Y</u>	1000	66 22	/ Fe	bruary 6,	2012
			30. Name and address of person wh		, ,,,,,	. ,				
	Charles and the same of the sa		31. Date filed (Month, Day, Year)		528 Boland F		Suite 10	4, German	town, MD.	20876
	Stat Registra		FEB 07 20	12 2	egistrar's Signature	All I				
				-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Buchman Perry Feb. 3, 2012 2256 Medical 4b. City, Town, or Location of Death Kensington 4a. Facility Name (if not institution, give street and number) c. County of Death Montgomery **Examiner** 3618 Littledale Road Apt.107 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours New Jersey 152-14-5169 98 7/16/1913 **Director** 1 M 2 XF Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Montgomery Kensington 1 K Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 3618 Littledale Road Apt.107 20895 USA ı "natural", or item edical Examiner ır 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1943
If Yes, Give 1945 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 1945 Completed 3 X Widowed 4 ☐ Divorced Year or Dates. other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) New York State College (1-4 or 5+) **5 +** Elementary/Secondary (0-12) Mental Hygiene. Public Schools School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Arthur Theodore Buchman Elizabeth Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Edmund F.S.Perry Jr./Son 9612 Glencrest Lane Kensington, Md. 20895 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Chesapeake Crem. 2/6/2012 Beltsville, Md 4 Donation Other (Specify) Weral Service Li 21. Signature PHILIP OF RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cerebro vascular accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hemiplegia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Atherosclerotic heart disease Due to (or as a consequence of) resulting in death) Last Physician/Medical Arthritis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the at Id be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify, 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 XX Natural 5 Pending To the Hospital or Attending Lwithin 24 hours after death.

To the Funeral Director: After completely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Ajay Reddy M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D53691

29d. Date signed (Month, Day, Year)

Feb.6,2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Feb 2012 Karlette Cecelia Proctor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Davs Hours Min Director 577-74-2276 1 🗆 M 2 💢 F 58 Yrs Aug 19, 1953 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location Director notified MD Gaithersburg Montgomery 10f. Zip Code 10g, Citizen of What Country? items 23a or ner must be n 5 10e Street and Number Funeral 20878 United States 834 Quince Orchard Blvd. #201 death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?

1 Yes 2 No Black, White, etc. Ь þ 1 X Never Married 2 Married Specify: American Indian 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Lillian Proctor Norbert Proctor traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 Quince Orchard Blvd. #201, Gaithersburg MD ge 1 and 2 sl nt of Health a Neal D Proctor/Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department of Important: If any injury or 2-6-2012 Glen Burnie Atlantic Crematory 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 21. Signature of Euneral Service Licensee Men 7 Park Ave., Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Metastatic Small cell cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Colon adenocarcinoma Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rand rtransit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy page 2 Proctor, Karleth 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? _ 2 **X** No 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: injury 1 X Natural 5 Pending thours after death.

uneral Director: Af
ely filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier wans 10

M.D.

Wang

06

Dongmer 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 X Yes 2 No

9:50 A M

Approximate Interval Between Onset and Death 9 month 23d. Date of delivery Month Dav 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) D0063828 02/03/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Ste 435, Rockville, MD 20850 32. Registrar's Signature ORIGINAL

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Craig 2012 Steven Proctor February 5:15 р М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral Director** 204-42-6444 1**₹**] M 2 □ F 59 Dec. 18, 1952 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3915 Warner Street 20895 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: than "natural", 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Δ other Director of Labor Management Marriott International Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Donald Proctor Marilyn Greenfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgil A. McCargo/Companion 3915 Warner Street, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 6, Feb. Metropolitan Crematory 4 Donation 5 Other (Specify) 2012 Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Lice Inc. Spring, R MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Bilateral Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) law requires that the death certificate be executed Cause (Disease or injury that initiated events Non-Hodgkins Lymphoma Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves 2 No has page 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Yes ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes Accident 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760 P.O. Records, Hospital or Attending Physician: The **Division of Vital** ours after death. neral Director: Aff filled in by the fu 24 hours Funeral completely To the within 2.

> 31. Date filed (Month, Day, Year)
> FEB 0 6 2012 State Registrar

29b. Signature and title of certifier

Farzad Malekanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (trem 23a) (Type, Print)

10

29c. License number

D65729

02/04/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical February 2012 1:00 AM Patton Betty Jane 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert County Nursing Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year) Wash. Min. Hours 1 □ M 2 👿 F Months D.C. 74 Director 578-48-0640 Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or itam on any injury or other traumatin 10b. County 10c, City, Town or Location 10a. State Director 1 Yes 2 X No Huntingtown Calvert 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 20639 130 Walton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Marie Co1e Haze1 Hobart Miller William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Walton Road, Huntingtown, MD Fred W. Patton, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
Burial 2
Cremation 3
Removal from State Metropolitan Crematory 02-09-12 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Find Stage Chronic Obstructive Rulmonary -Immediate Cause (Final Physician/ End disease or condition Medical resulting in death) Disease Examiner Sequentially list conditions, Examine Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📆 No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an congestive autopsy performed? 1 Yes 2 No this certificate has pade 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be funeral director. Other: 4 🗖 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: s after death. 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital within 24 hours of To the Funeral I Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

JRW) State

Registrar

Road

If the time and place and due to the causes and manner as stated

SURANA

D. 50653

Deale

29d. Date signed (Month, Day, Year)

-8-2012

3 Certifying Nurse Practioner: To the best of my Impolledge

wono

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GyA)V C

Deale Church ton

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Eyon-C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Depar Registrar Certif	tment of Health and I <i>ficate of Death</i>		plene leg. No. 2012 05728
Н	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Earnestine Josephine Jones Po	ro11	2. Date of Deat	th 3. Time of Death
ade in	Medic Examir			4b. City, Town, or Location of Death	January	29 ,2012 11:21 P.M 4c. County of Death
-			2208 Connecticut Avenue	Landover		Prince Georges
	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Year)1934 Country)
	how at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion	0ctober	18, Maryland 10d. Inside City Limits
	Marylar 8a-f sl	Director	Maryland Prince Georges Lando			1 X Yes 2 □ No
	th the I	al Di	10e. Street and Number	10f, Zip Code		10g. Citizen of What Country?
	ems 2.	Funeral	2208 Connecticut Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20785 s Decedent of Hispanic Origin? (Sp		United States 14. Race - American Indian,
9000	vurs after de tural", or it al Examine	by	1 Never Married 2 X Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, 2 X No If Yes, Give Year or Dates.	es, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show iter the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give kin Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation of of work done during most of work NOT use retired) or of Commissary		16b. Kind of Business/Industry U.S.Department of Defense
yland	d be filed wit Mental Hygie arked other atic event, th	To Be	17. Father's Name (First, Middle, Last) Alvin Jones	18. Mother's Nam Rozen	ne (First, Middle, M a Spri	
Man	d 2 shoul alth and 1 1 27 is ma		James Powell (Husband) &	Address (Street and Number or Rur Atlantis Drive;		
more,	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposit cemetery, cremati		Date 9,2012	20c. Location - City or Town, State Cheltenham,
Balti	permit. Departm Imports any inju		Signat. of Funeral Schoolingensee	Name and Address of Facility ${f R}$.	N. Horto	on Company Morticians, W.; Washington, D.C. 2001
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.			
3434	Physician/ Medical		Immediate Cause (Final disease or condition republished in death) Terminal Stomach	Cancer		Onset and Death
	Examiner		Due to (or as a consequence of):			
	n #	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	kecuter and al-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
092	icate be executed physician and is the burial-transit	edical	d			
9289	ertificat ding ph se as th	/Mec	IF FEMALE: 23b. We decoded grapher 23c. If yes, outcome of pregnancy			
). Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.C	ires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the und Hypertension	erlying cause given in Part I.		pacco use contribute to the cause of death? es 2 X No 3 \square Probably 4 \square Unknown
corc	law require has been si ge 2 should I	Completed	Osteoporosis		24a. Was ar autops	
Re	nysician: The lav nis certificate has I director, page 2				perform 1 Yes	
/ital	/sician s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: I I Inpatient 2 ER/Outpatient	26. Place of Death (Chec		ence 6 Other (Specify)
Division of Vital Records, P.O.	nding Phy ath. r: After thi ne funeral	Certificate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2 No		w injury occurred
Divisi	al or Atters al Safter de al Directo ed in by the	l Certii	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation of the best of my knowledge, death occurrence (Check only one)	ation, in my opinion, death occurred a	t the time, date an	d place, and due to the cause(s) and manner stated.
	To the contract of the contrac		29b. Signature and title of certifier	29c. License number 0 13339		9d. Date signed (Month, Day, Year) February 3, 2012
	DD		30. Name and address of person who completed cause of death (item 23a) (Type, Prin	0	am Drive	; Suite A
	Stat	e_	Tsunie Chanchien, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	College Park,	Marylan	d 20704
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's signature 33. Registrar's signature			

DHMH 17 Rev 06-2011 ** • -

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr g924 2-27-12 yt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEB.10,2012 THOMAS LINDBERGH PROCTOR 11:16PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LA PLATA CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-23-1933 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-36-3132 78 **Director** 1 🔀 M 2 🗆 F BEL ALTON, MD 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD. CHARLES INDIAN HEAD 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 5619 MASONS SPRING ROAD 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, AMERICAN 1 Yes 2 X No If Yes, Give Year or Dates. by 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: INDIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION CO'S. CONSTRUCTION WORKER 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မှ CLEMENTS PROCTOR MARY ALBERTA HARLEY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a ELIZABETH PROCTOR-SISTER 7609 OLD ALEX.FERRY RD. CLINTON, MD. 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or ST. INGNATIUS CEM. Department of Important: If any injury or 2-16-2012CHAPEL POINT, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 7M00479 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or Exami executed and trar Due to (or a /a resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 \(\subseteq \) Live Birth 2 \(\subseteq \) Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural Accident 5 Pending death. I Director: A ed in by the fr Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide hours after City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

Michael A. Leatherwood

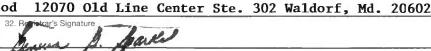
of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 [

31. Date filed (Month,-Day, Year)

29b. Signature and title



Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

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the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lvdia S. Ramirez February 2012 7:45 P ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1529 Tucker Road Ft. Washington Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days 037-68-9964 1 🗆 M 2 🗙 Director 81 01/21/1931 Philippines | Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2x XNo Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1529 Tucker Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married **p** Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 1 ☐ Yes 2 No Specify: Specify: Filipino Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) In Home 6th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve Sugundo Sebastian Candida Fajardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fercival S. Ramirez / Son 1529 Tucker Road Ft. Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any Injury or o once. 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 2/11/2012 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature Peral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2xxx No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy perform death? Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X X latural work? 5 Pending injury 2 🗌 No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2012 Physician/ Gerard ROHDE 9:22 A February Medical 4b. City, Town, or Location of Death Rockville 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 6050 California Circle #103 Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 28 9. Birthplace (State or Foreign Social Security Number last birthday Funeral 1920 Massachusetts 1 **X**M 2 □ F 91 017-16-4809 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State Director 1 Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 6050 California Circle #103 Funeral United States be filed within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify "natural", 3 Widowed 4 Divorced Completed WW II 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Attorney/Admin. Law Judge other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) l Hygiene. other than " Civil Rights Law Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hyman Benedict Rohde Leonora Stitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19 W. 70th St., #B, New York, NY Ira Rohde, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any injury or oth 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 02/08/12 Cheltenham, MD 4 Donation 5 Other (Specify) Toroninskysblebnew Funeral Home f Funeral Secure Line UCIDOS 254 Carroll St., NW, Washington, DC 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part Atherosclerotic Cardiovascular Disease Immediate Cause (Final Physician/ Years disease or condition resulting in death) Medical Due to (or as a consequence of): Years Examiner Hypertension Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Years s the burial-transit Diabetes Mellitus To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ed by the a detached f a I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Alzheimer's Disease page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3

10+1

29b. Signature and title of certifie

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

29c. License number

D 20516

Schulman, M.D., 6000 Executive Blvd., Ste. 3000, Rockville, MD

29d. Date signed (Month, Day, Year)

February 6, 2012

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per inf g926 4-30-12 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Voor P^M Ruth Beinish Robinson 29 2012 2:30 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Spring House/Manor Care Bethesda If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. (Month, Day, Year, 22-1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 □ M 2 🗓 F Months Director Yrs 28-78-4737 85 Isrea1 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Winterberry Court Bethesda United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) and Mental Hygiene. College (1-4 or 5+) the Piano Teacher 1+ · filed v traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ Mordechai Beinish Malka Yurman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Robinson - Daughter 3601 Conn. Ave. #411, Washington DC, 20008 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Judean Gardens 2-1-2012 Olney, Maryland 21. Signature of Funeral Service LicenseeVictoria Seaman 22. Name and Address of Facility Edward Sagel Funeral Direction #M01641 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Aspiration Pneumonia Days Medical resulting in death) Due to (or as a consequence of) Examiner Months Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ò Month Day Pregnant at time of death detached the g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò should be The law requires Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 Z No certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica hin 24 hours after death.

the Funeral Director: After this certifical

mpleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MA90976 1-31-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Oskoui, Ramin MD -

2012

31. Date filed (Month, Day, Year FEB 09

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

of Vital

Division

Registrar's Signature

3301 New Mexico Ave. #316, Washington, DC 20016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Februar u Physician/ 11 P M 2017 mich Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** nam Home Beens If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) Security Number 6. Sex **Funeral** Year) 1918 April Day Ye 1 M 2 K F Days Hours Pennsylvania 216-80-0768 93 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State with the Maryland be notified at Director Hagerstown Washington X Yes 2 ☐ No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral 21740 U.S.A. 23a 735 George Street **Examiner must** items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No ō, δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Specify: 'natural", Completed 3 X Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N her own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Maude L. Barnhart Roy J. Freet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21234 Twin Springs Drive, Smithsburg, Maryland 21783 Jesse A. Rowe, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February 16, 2012 1 X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland Rest haven Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to fining data cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?
1 Yes 2 No Month Pregnant at time of death ☐ Yes ∠_r ☐ Unknown been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has 1 Yes 2 No Yes 2 N certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred funeral 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A Investigation Accident the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practionar To the Sest of my Howledge doubt occurs did the firm, date and place, and due to

State Registrar 29b. Signature and title of certifier

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30. Name and address of perso) who completed cause of death (Item 23a) (Type, Print)

To the I

DOWN

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egistrar's Signatu

29c. License number

Hagerstown

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RASMUSSEN Month OHANNES 2012 2:56 p.m. Medical February 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Apt. 3201 22680 Cedar Lane Court, <u>Leonardtown</u> Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Director 1 XM 2 □ F 295-07-1528 Usual Residence of Decede 92 09/04/1919 South Dakota show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 X Yes 2 No Maryland St. Mary's Leonardtown 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20650 United States 22680 Cedar Lane Court, Apt. 3201 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 X Widowed 4 Divorced Specify: Year or Dates White 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Musician U.S. Marine Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Led Johannes Rasmussen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 42487 Riverwinds Drive, Leonardtown, MD Cheryl Ciecka/Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 02/15/2012 Charlotte Hall, MD Signal Juneral Service Censee Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any example of the result of the cause. Enter Underlying Cause (Disease or injury that initiated events could be indeed to be caused the cause of the caus Examiner Date to for as a consecution of use as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Yes 2 No detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗆 No 1 🗶 Natural 5 Pending s after death. 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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within 2 To the I

Box 68760

P.O.

Division of Vital Records,

Registrar

DHMH 17 Rev 06-2011

State

40900 merchants in

D 71807

16hr

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson

strar's Signature

29d. Date signed (Month, Day, Year) February 15,2012

Lemantinin, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G925 3/01/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Billy Physician/ Lee Rich Month 1230 PM 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs. - 409 S42 ±6326 Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Hours Min (Month, Day, Year) **Director** 409 62 6326 1**X** M 2 □ F 79 10/23/1932 Tenn. Usual Residence of Dece 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Talbot Easton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 40 Kensington Dr. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or þ 1 Never Married 2XXMarried 21215-0036 1 Yes 2X No Specify. White Specify. Completed 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) United States Air Forc Tech Sargent Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Randall Delong Rich Franceola Hudges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Rich/ Wife 40 Kensington Dr. Easton, MD. 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Brinsfield-Echols Crem. 2/11/12 1 Burial 2XXCremation 3 Removal from State Charlotte Hall, MD 4 Donation 5 Other (Specify) fure of any in once, AREHART ECHOESTY FUNERAL HOME, PA P.O. M00945 Box 567 LaPlata, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence 📳 Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached the 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 X No 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 → Ho Hospital Other: မ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and ti 29d. Date signed (Month, Day, Year) \$\$65656 completed cause of death (Item 23a) (Type, Print) 210 31. Date filed (Mo Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ()2 Physician/ 2001 Medical ity Name (if not instit 4c. County of Death **Examiner** 6HUIMORE 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Director 578-46-0672 1 🕅 M 2 🗆 F 77 July 7, 1934 Washington DC Usual Residence of Deceder 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Calvert 1 Tes 2 X No Huntingtown Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2813 Beach Drive 20639 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Experience. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) House/Garage Elementary/Secondary (0-12) College (1-4 or 5+) Owner/ Home Builder 12 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Suit Ritchie Mildred Ryon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Ann Ritchie - Wife 2813 Beach Drive, Huntingtown, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place, 2012 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Sign sture of Funeral Service License MaErgh 8200 Jennifer Lane, Owings, MD 20736 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one eause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** REMIFICATIONS PROVED BY MEDICAL EXAMINES Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami use as the burial-transi and Due to (or as a consequence of) nding physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 📉 No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending COLLSION motor venicle Le I Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Pl ce of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined lum Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) JRV 30 Street, Baltimore, MD 21201 South atherine Nelson

State Registrar 32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:05 pm February 04, Seymour Rich 2012 /Medical 4a. Facility Name (If not institution, give street and number) Examiner Collingswood Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 28, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F 93 Director Pennsylvania 578-07-5917 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 299 Hurley Avenue, #183 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 ģ Specify. 3 Widowed 4 □ Divorced Caucasian Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed withi if Health and Mental Hygiene. item 27 is marked other than 12 Restauranteur Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abe Rich Tillie Goldstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald J. Rich - Son 10525 Prairie Landing Ter., N. Potomac, MD 20878 permit. Pages 1 a Department of Hea Important: If item any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grdns 02/07/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Line Neva M0162 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of that the death certificate be executed buriantrapsi and Due to (or as a consequence of Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir P 27. Manner of Deat 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours after death To the Funeral Director: completely filled in by the it

State Registrar 29b. Signature and

Ahmed Heshmat,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

29c. License number

7133 Mill Run Drive, Derwood, Maryland 20855

29d. Date signed (Month, Day, Year) 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alexis Rae Spradling February 2012 12:25 P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins University Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 212-63-7447 Director 1 □ M 2 🗓 F 10 12/4/2001 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3664 5th Avenue 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene.

is marked other than "natural", White Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Brent Spradling Julia Geisenheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brent Spradling/ Father 3664 5th Avenue, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 2/10/12 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 Yes 2 No Yes 2 (XN) ופ Funeral Director: After this ניסיוים: היייה אין וה Py the funeral director, מורח הייה וה the Hospital or Attending Physician; 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 2 No ပ 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

600 North Wolfe St., Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

strar's Signature

2/3/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Nathan Switzen :30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home Of Greater Washington Rockville Montgomery Social Security Number Sex 1X M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Month, Day, Year, -29-1919 Director 92 Poland 121-03-3777 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Montgomery Rockville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose St. 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give 3X Widowed 4 □ Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hyman Switzen Anna Kolman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Lynch - Daughter 10078 Green Clover Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wellwood Cemetery 2-1-2012 Pinelawn, New York 21. Signature of Euperal Service Licensee MOILC 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville, Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) mentia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tr nsit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 2 No 4 ☐ Pregnant
9 ☐ Unknown the 9 Unknown cate has been signed by to page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No πpleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do064871 31-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd Rockville MD 20852 Mina

State

Registrar

La than

6/21

32. Registrar's Signature

Fazli

09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 12:45 PM February Betty Jean Small Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Months **Director** 86 579-26-4883 1 🗆 M 2 🗶 F January 17,1926 Washington,DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State rector 1 X Yes 2 No Maryland Gaithersburg Montgomery 百 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20879 United States 816 Gallop Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working /giene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Insurance should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev ျ James Vernon Baker Rose Duval 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Gallop Hill Road, Gaithersburg, Maryland 20879 John S. Small, Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Fort Lincoln Crematory 2/14/2012 Brentwood, Maryland Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute Kawe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and De Ph. sician/ months Failure To Thrive disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last 10 Due to (or as a consequence of) nding physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) the hed Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Deep Vein Thrombosis 24a. Was an ate has autopsy performed? Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Hospital: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this

completely filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State

6

Medical

29a. Certifier (Check

only on

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

February 7, 2012

29c. License number

D0028656

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 5:00 Α Renee Schneider Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Nightingale House Darnestown Montgomery If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Min Country) 1 □ M 2 🕅 F 074-22-5409 Director New York 81 8-11-1930 Usual Residence of Decedent show 10b. County 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location notified at Director 28a-f Montgomery Gaithersburg X Yes 2 □ No MD 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 14901 Braemar Cresent Way 20878 United States items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 Never Married 2 Married φ Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Foreign Language Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Charles Woolf Bertha Yusen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Department of Health Important: If item 27 any injury or other tr Stanley D. Schneider - Husband 1401 Braemar Crescent Way, Gaithersburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Mt. Pleasant Cemetery 2-10-2012 Hawthorne, New York 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville, Pike, Rockville, Maryland 20852 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysiciani Astrocytoma Years disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease of Ilinjury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician a detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Yea Pregnant at time of death Other (specify) 4 ☐ Pregnant
9 ☐ Unknown Yes 1 Yes 2 L 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 🏻 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?
1 Yes 2 No pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Hospital 2 🛚 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🕅 Natural injury 5 Pending 1 Yes 2 | No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Dolinsky MD,

09

31. Date filed (Month, Day, Year)

FEB

20148

911 Russell Avenue, Gaithersburg, Maryland 20879

2-7-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norton SAVAGE 2012 February 11:30 A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 1207 Devere Drive Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Apr. 23 Days 1 XM 2 - F Months Min. 130-05-7667 Director Pennsylvania 918 93 Usual Residence of Decedent 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shooten traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Ves 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20903 1207 Devere Drive 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceden 2.... Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify. white Completed 3 Divorced 4 Divorced Specify Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ U.S. Dep't. of Energy <u>Electrical Engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sonia Brook Morris Savage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1207 Devere Drive, Silver Spring, MD May Savage, Wife permit. Page 1 and 2 Department of Health Important: If item 2 injury or other 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/10/12 National Capital Hebrew Cemetery Capitol Heights, MD 4 Donation 21. Signature of Funeral Se L 22. Name and Address of Facility LOrchinsky Hebrew Funeral Home Carroll-St., NW, Washington, DC 20012 23a. Pan + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Y Partsnd Death Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial transit that initiated events Due to (or as a consequence of) resulting in death) Last Medical that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Yes 2 No 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? 1 Yes 2 No Be of Vital 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🔼 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No Division s after death. ☐ Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 20 29d. Date signed (Month, Day, Year) February 7, 2012 D 09834

Registrar

State

Barry N. Rose
31. Date filed (Month, Day, Year)

Rosenbaum, M.D., 3720 Farragut Ave., 2nd Floor, Kensington, MD

20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State Registrar	State of Marylar			lealth ar	nd Mental Hy		gible.	571.1
	Physic Med		Mary L.	Sanders				2. Date of De Month Feb •	eath Day	Year	me of Death : 24P M
	Exam	iner	4a. Facility Name (if not institution, giversity Southern Mary)	,	1	4b. City, Town, or Clintor			4c. Count	y of Death	
	Funera Directo	_	5. Social Security Number 6. S 247-68-2702			If Under 1 Year Months Days	If Under 24	Min. (Month, Da	th ay, Year)	9. Birthplace (Si	tate or Foreign
	aryland la-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc			7/2/	1939		de City Limits
	vith the M 23a or 28 st be noti	ral Dire	DC 10e. Street and Number		shingt	10f. Zip Code			10g. Citizen of		Yes 2 No
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	20019 /as Decedent of His Yes, specify Cuban Yes 2 X No	panic Origin' , Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	USA 14. Rac Blac Specify	e - American India ck, White, etc.	n,
Baltimore, Maryland 21215-0036	within 72 hour giene. her than "natu t, the Medical	Completed	15. Decedent's E (Specify only highest gr.	ducation	(Give ki life. DO	ent's Usual Occupa ind of work done du NOT use retired)	iring most of	working	16b. Kind of B	Black usiness/Industry e Indus	:trv
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e, Mar	and 2 shou Health and em 27 is m ther traum		19a. Informant's Name/Relationship (To Temega Sanders 20a. Method of Disposition	/Daughter	4354	Address (Street and D St.	d Number or	Rural Route Number	; City or Town, S	tate, Zip Code)	
altimor	Pa ant ant		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Licens	Removal from State Was		on nati		Date 10/2012	Suitla	City or Town, State	
B	Departic Departic Imports any inju	L	• /	cc027	8 3	831 Geo	rgia	atney s Ave. NW	Washin	l Home, gton,DC	Inc. 20011
	Physician/ Medical Examiner	er.	23a. Part 1. Enter the diserile, or companions, or heart failure, List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Acue Due to (or as a conseque	Atensence of):			ac or respiratory arm		Approxi Interval Onset a	mate Between nd Death
09	certificate be executed nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
Š S	death certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal (4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌 E	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day	Year
rds, P.O	squires triat sen signed t	by	Part II. Other significant conditions con	ntributing to death but not result	ting in the und	erlying cause given	in Part I.			oute to the cause o	
II Records,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the properties of the funeral director, page 2 should be detach.	Completed	25. Was case referred to medical					24a. Was ar autops perform 1 Yes 2	y pr ned? de	ere autopsy finding ior to completion oeath?	s available f cause of
I VILA	this cert	To B	examiner?	ospital:		Other:		eck only one) Home 5 Reside	nce 6 7 Other	(Specify)	
VISION OF	death. ctor: After y the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)		28c. Injury at work? M 1 Yes	2 □ No	28d. Describe how			
Sprits or A	neral Dire		4 Homicide determined 29a. Certifier 1 Certifying Physic	28e. Place of Injury - At home building, etc. (Specify)				City or Town,	State)	or Rural Route Nur	nber,
o the Ho	within 24 hours after To the Funeral Dira Completely filled in	Med	(Check 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of my knowled rr; On the basis of examination a Practitioner: To the best of my	ge, death occi nd/or investigat knowledge, dea	ath occurred at the t	me, date and	, and due to the caus at the time, date and place, and due to the	se(s) and manner place, and due to cause(s) and mar	as stated. the cause(s) and noner as stated.	nanner stated.
	3 8		· 8/5			29c. License nu	mber	7	d. Date signed (I	Month, Day, Year)	•
	State		30. Name and address of person who con	149 7503	SUL	rasts	Bol	.Clint	m,nc	id 207	135
	Registra	-	FER 0 9 2012	32. Registrar's Signature	part				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:55 PM Ruth Alverta Spikes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medica1 Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 1 □ M 2 💢 F <u> 219-20-1678</u> 85 Usual Residence of Deceden 03/04/1926 Maryland 28a-f shov 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 □ No Maryland Washington Hagerstown ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral U.S.A. 381 Yorkshire Dr. 21740 ral", or items? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 8 Machine Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chalmers S. Gordon Edith A. (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Phillip Spikes, Jr. / Son 13525 Paradise Church Rd. Hagerstown Maryland 21742 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/13/2012 | Hagerstown, Maryland Rest Haven Cemetery 21. Sign are of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Acut empala Medical resulting in death) Examiner Cartiorngular Sequentially liet or ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and if for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 Unknown should be detached the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? δ Feilure Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Tes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DU \$ 38 761 113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nedia Itex-Tion my ZIAYZ R166 LE R7 STE 127 0. 01111 mo 31. Date filed (Month) gistrar's Signature State 3 201 Registrar

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even Edward S		ner State of Maryland / Department of Certificate o		id Mentai		2012	05745
		Registrar 1. Decelent's Name (First, Middle, Last)	Dealli		Re 2. Date of Deat	eg. No.	3. Time of Death
Physicia ledical Exami	an/ ner				Month February 8		1515 hrs
		Facility Name (if not institution, give street and number) 18633 Northaven Street	4b. City, Town, or Hagerstown		ath	4c. County of Death Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-80-4197 1	If Under 1 Year Months Day		Irs. 8. Date of Birt fin. 12/23/	h(MM/DD/YYYY) 9. Bird /1958 Foreig	thplace (State or in Mary Land untry)
	ı	Usual Residence of Decedent					
and show any nce.	9	Maryland Washington County Hagerstow					10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 18633 Northaven St.	10f. Zip Code 217	42	10	Og. Citizen of What Cour	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show the content traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married 1 Yes 2 No	/as Decedent of Hi Yes, specify Cubar	n, Mexican, Pue	Specity Yes or No- rto Rican, etc.)	14. Race - Ameri White, etc. Specify: Whi	can Indian, Black,
irs afta	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupa	tion (Give kind		16b. Kind of Business/l	ndustry
1215-0036 d be filed within 72 hou fental Hygiene. narked other than "nat event, the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life $oldsymbol{ iny ronics} T$			Defense Co	ontractor
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Ö	17. Father's Name (First, Middle, Last)			me (First, Middle, M		
216 be file ntal H	Be	Phillip Owen Skinner			Lee Auch		
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the jajury or other traumatic event, the Med	٤	Richard Skinner-brother 1780	6 Timber	lane Ha	gerstown,	ber, City or Town, State MD 21740	
re, land f. Heal f. Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crematory or Communication	other place)		Date	20c. Location - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:	0	,	-11-2012		
Balti permit. Departm Imports					_	Fiery Fund	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying	, such as cardia	c or respiratory arre	Hagerstown est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Hypertensive Cardiovascular Disease Due to (or as a consequence of):	ase				Death
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.					
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of): d.					
be exectician a	dical	UNPENDED AMENDED					
8760 ificate I ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 2 3c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3	Ectopic pre	gnancy	23d. Date of delivery Month	/ Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Med	past 12 months?	Other (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Ď	Part II. Other significant conditions contributing to death but not resulting in the Chronic Alcohol Abuse with Cirrhosis of the Liver	underlying cause	given in Part I.		bacco use contribute to	
ords w requires been should	Completed				24a. Was a autop:	sy prior to d	topsy findings available completion of cause of
Reco The law cate has	mo				perfor 1 ✓ Yes		es 2 No
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner? Hospital:		of Death (Che			
of Vil ing Physic After this funeral dir	T _o	1 Ves 2 No 1 Imparent 2 Evolupation 27. Manner of Death (Month, Day, Year) 28b. Time of	f Injury 28c. Inju	ury at Work?		Residence 6 Other	: Scene
/ision r Attend ter death. irector: n by the f	Certification:	1 V Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Yes 2 No	28f. Location (S	Street and Number or Ru	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:		4 Homicide determined (Specify)	urred at the time, o	date and place, a			ed.
o the I o the F o the F	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig				and place, and due to th	e cause(s)
HSHS	Me	29b. Signature and title of certifier	29c. Licen	se number		29d. Date signed (Mo. February 9, 2012	
		30. Name and address of person who completed cause of death (Item 23a)					
W-4+1		Russell Alexander MD. Assistant Medical Examiner 900	W. Baltimore	Street, Bal	timore, MD 212	223	
S	tate	31. Date filed (Month, Pan Year) 2012 32. Registrar's Signature	aske				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) February 10 2012 5:38 Physician/ Ам Kevin Todd Staley Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hagerstown 17813 Garden Spot Dr. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days April Day Hours Min. 1 💢 M 2 🗆 F 56 Mary land 219-68-2425 Director Usual Residence of Decedent 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director 1 🗆 Yes 2 🎖 No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 Funeral 17813 Garden Spot Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?_ 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Correctional Officer State Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Eleanor C. McMillen မ Aaron L. Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 17813 Garden Spot Dr. Hagerstown, MD 21740 Wendy B. Staley-wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Hagerstown, MD 2-13-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final P ician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate makes Filler Inderlying Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 I Inknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No After this certificate within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 XNo 5 Residence 6 Other (Specify, 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation ∐ Acciden □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Wedlad Examiner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State Registrar

JW-12

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

S

29d. Date signed (Month, Day, Year)

4/30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 7:38 February James Bryon Shue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Mechanicsville 42321 Calvert Circle 8. Date of Birth (Month, Day, Year) 05/12/1954 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 6. Sex 1 M 2 □ F Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours 57 Director 215-62-8312 Washington.DC Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No Mechanicsville Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral filed within 72 hours after death with USA 20659 42321 Calvert Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2X Married ģ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Locksmith Security Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ pe Evelvn Pruett Douglas Shue, Sr. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 42321 Calvert Circle, Mechanicsville, MD 20659 <u>Mary Shue/Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Brinsfield-EcholsCrem. 02/10/2012 Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of FacilitBrinsfield-Echols F.H, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Deat Immediate Cause (Final Physician/ March disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician Physician/Medical NGNOWN Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Ves 2 No s been signed by the solution should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? 26. Place of Death (Check only one) Be 25. Was case referred to medical funeral director, examiner? Other: 4 Nursing Home 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be after death

Director: A
d in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direcompleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Bev 7/2009

Name and address of person who

FEB14

31. Date filed (Month, Day, Year)

Gld Line

leted cause of death (Item 23a) (Type, Print) 126 To

Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Legible.
State of Maryland / Department of Health and Mental I	Hygiene
Certificate of Death	Reg. No. 2 () 2

		_ For		State	of Marylar	nd / Depa	artment of	f Health	and N	lental Hy	giene	Э		
		State Registrar				Cer	tificate of	f Death			Reg. No	. 2011	2 0	571.8
13.1		1. Decedent's Na	me (First, Middl	e, Last)						2. Date of De	ath	2016	3. Time	of Death
Physicia Medic		Laura	Ellen	Brooks	Smith					Month Februa:	ry $ extstyle extstyle$	4, 2012	9:35	p.m.M
Examin		4a. Facility Name	(if not institution	n, give street and no	umber)		4b. City, Town	, or Location	of Death		40	c. County of Deat		
		44633 S	hallow	Ford Cour	rt		Tall T	imbers			S	t. Mary	's	
Funeral		Social Security		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yes		er 24 Hrs. Min.	8. Date of Bir		9. Bir	hplace (Stat	e or Foreign
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death v items	ij.	11. Marital Status		12. Was De	ecedent Ever in U.		Vas Decedent o	f Hispanic O	rigin? (Spe	cify Yes or No-	OHLI	14. Race - Ame		
or it	by F	1 Never Ma	arried 2 X Ma	rried 1 🗌 Ye	Forces? s 2 X No		Yes, specify Cu			Rican, etc.)		Black, White	e, etc.	
ırsafi ural", IExa	pa	3 🗌 Widowed	4 Divorced	d If Yes, G Year or		1	☐ Yes 2 🛣	No Specif	y:			Specify: Wh	ite	
2 hot.	Completed	(S		nt's Education est grade complete	ed)		ent's Usual Occ ind of work dor		st of worki	ina	16b. F	Kind of Business	Industry	
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should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 'sumatic event, the Medical Examiner must be notified at	To E		,,,	7						e (First, Middle,		Surname)		
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2 sho th and 7 is i		19a. Informant's					,					r Town, State, Zip		2600
and Healt		James S	Smith/Hu	sband	20h E	-	Shallo sition (Name of	w Ford				imbers,		0690
permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.		1 🗌 Burial	2 XCremation	3 Removal fro	om State	emetery, crem	atory or other p	1		Date		ocation - City or		
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permi Depar Impo any ir		1/10	Bacer	N. YR	01631	22	2055 Ua	1 1	Bri	nsfield	Fur	neral Ho ltown, M	me, P. D 206	.A.
		23a. Part 1. Ente	_	Hicks M r complications tha								icowii, ri	Approxin	
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t the by th	Phy	9 Unknov												
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requires been sig should b	ted									1 🗆	Yes 2	No 3□P	obably 4 L	_ Unknown
has b	nple									24a. Was autor	osy		opsy finding completion o	
The cate is	Cor									1 Yes	rmed?- 2 X N	death?	2 🗆 No	
certifi	Be	25. Was case refe examiner?		Hospital:				Place of De	ath (Check	only one)				
Physical direction	: To	1 Yes 2	2 No	1	Inpatient 2 te of injury	ER/Outpatien 28b. Time of	1 3 LL DOA					Other (Spec	ify)	
ding h. h. After fune	Certificate:	1 Natural	5 Pendi	ng (Mo	onth, Day, Year)	injury		jury at ork? □ Yes 2 [28d. Describe h	low injur	y occurred		
deat ctor: y the	ţįį	2 Accident 3 Suicide	6 🗌 Could	not be	ce of Injury - At ho	me farm stre				28f Location /9	Stroot an	d Number or Ru	nl Poute Nu	mher
after Direction b		4 Homicide	e detern		lding, etc. (Specify		ot, ractory, onle			City or Tow			ar House War	riber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier	1 Certifying	Physician: To the	e best of my know	ledge, death o	ccurred at the ti	ime, date an	d place, ar	nd due to the ca	ause(s) a	and manner as st	ated.	
n 24 l n 24 l ne Fu	Med	(Check only one)	2 Medical I	Examiner: On the b Nurse Practition	pasis of examination	n and/or investi	gation, in my op	inion, death o	occurred at	the time, date a	ind place	e, and due to the o	au se (s) and i	manner stated.
vithi To t		29b. Signature an	d title of certifie	r	3		29c. Lice	nse number			29d. Da	te signed (Month	, Day, Year)	
			(-)	2/1/	(1)		1	1/109	557	5		2-15-	12	
		30. Name and ad	dress of person	who completed ca	use of death (Item	23a) (Type, P	rint)	- V - V				100		
genee		Jennife	r/Schmi	dt, D.O.	40900 N	1erchan	ts Lane	, Leo	nardt	own, MI	2	0650		
Stat	е	31. Date filed (Mo	FFR 1	ፍ 2012 ³²		ture.	,							
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month -03A Physician/ 2012 RFNE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Lanham 8405 Red Wing Lane If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7 Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min **Director** 578-52-1854 1 🗆 M 2 🖵 73 Feb. 2, 1938 Virginia Usual Residence of Dece 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location aţ 10a. State 10b. County Director be notified 1 Yes 2 XNo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Examiner must 20706 8405 Red Wing Lane "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 Divorced African American Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) United States Federal Government and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Paralegal of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Emma Rollins Everette M. Banks, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8405 Red Wing Lane Lanham, MD 20706 John H. Starks, Jr./ Husband or other 20b. Place of Disposition (Name of cemetery, crematory or other place National Remetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 2/8/2012 Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cu Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) executed Cause (Disease or injury that initiated events resulting in death) Last -trar Due to (or as a consequence of) burialattending physician I for use as the buris Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 9 Unknown the Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 1 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1100 မြ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No atural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b, Signature and title of certif 29d. Date signed (Month, Day, Year) 2 Name and address of person 10

Registrar

DHMH 17 Rev 06-2011

State

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3 2012

31. Date filed (Month, Day,

		For State	ease			nd / Dep	artme	ent of F	lealth		Mental Hy		_	ibie.	
		Registrar 1. Decedent's Name (First, Manager)		·)		Ce	rtifica	te of L	Death		2. Date of De		1	12	3. Time of Death
Physicia Medic Examin	al	Willie Shepper	tion, give s		nber)				Location	of Death	Jan.	27,	201: c. County	of Death	10:36P.M
Funeral Director		Gilchrist Hos 5. Social Security Number 229-46-1503	6. Se		7. Age (<i>In yr</i> s.			ler 1 Year s Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		9. Birth Cour	**
	ector	Usual Residence of Deceder 10a. State 10b. Cou	nty	eorge's	10c. C	ity, Town or Lo	ocation				8/21/19	937		Virg	inia 10d. Inside City Limits 1 XX Yes 2 □ No
n with the Ma is 23a or 28 nust be noti	Funeral Director	10e. Street and Number	urt				10f. 2	Zip Code				-	Citizen of V		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed XXX		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	e		If Yes, sp	ecify Cuba	ispanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)			k, White,	can Indian, etc. ack
within 72 hou giene. er than "nati the Medica	Completed	15. Dec (Specify only h Elementary/Secondary (0- 12				(Give life. E	kind of w OO NOT u	sual Occupiork done of se retired)	during mos	t of worki	ing		Kind of Bu	siness/Ir	ndustry
uld be filed d Mental Hyg marked oth natic event,	To Be	17. Father's Name (First, Midde Patrick Henr 19a. Informant's Name/Relati	y She		n				18. Moth	tie	e (First, Middle, Terry	Maider	n Surname		
and 2 sho Heatth and em 27 is I		Leah G. Mille 20a. Method of Disposition		Partner			3 Me	vs Co		Laur	el, Md.	20	707		
nit. Page 1 artment of ortant: If it injury or o		1 Burial 2 XXCremat 4 Donation 5 Oth 21. Signature Funeral Servi	er (Specify,		State	ntt Cr	matory or emato	other plac	se)	2/2/	2012 bert E.	Wa1	dorf	Ma	own, State ryland ralHome
Dep Imp any		23a. Part 1. Enter the disease	1	lications that	caused the dea	10	5000	Anna	polis	Roa	d, Bowi	e,			
Physician/ Medical Examiner		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	st only on	e cause on ea	ich line. Mg. CA (dras a consec										Interval Between Onset and Death TWO YEAR
e be executed ysician and e burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c	or as a consector										
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To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the t	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	1 Live	come of pregn Birth 2 Fe nant at time of nown	tal death 3	Ectopio	c pregnanc specify)	у				23d. Dat Mor		pery Day Year
equires that the sen signed by ould be deta		Part II. Other significant con	ditions con	ntributing to d	eath but not re	esulting in the	underlying	g cause giv	en in Part	1.					he cause of death?
Physician: The law re r this certificate has be eral director, page 2 sh	Completed	25. Was case referred to medi	al l					00.00			1 Yes	psy rmed?	p	rior to co eath?	ppsy findings available ompletion of cause of
Physicial this certi al directo	To Be	examiner?			Inpatient 2	4		Othe	4 ∐ Nu	ırsing Ho	me 5 🗌 Resid				HOSPICE
tending Facth. tor: After the funer	Certificate:		nding estigation uld not be		th, Day, Year)	28b. Time o injury	М			No	28d. Describe h				
spital or A			ermined	buildi	of injury - At h	fy)			. date and		28f. Location (S City or Tow and due to the ca	/n, State	e)		I Route Number,
o the Hos vithin 24 h o the Fur completely	Medical	(Check 2 Medic	al Examin ing Nurse	er: On the bas	is of examination	on and/or inves	tigation, i	n my opinio	n, death oc ne time, dat	curred at	the time, date a	nd plac he caus	e, and due	to the ca anner as	use(s) and manner state stated.
		30. Name and address of pers	on who co	ompleted caus	e of death (Ite	m 23a) (Time	Print)	26	430	75		JAI	NUAK	24 0	18,2012
W State		DANIEUE DO	BERI	MAN I I	US 63	336 C	EDAX	2 LAI	VE	COL	umbi.	A, 1	us 3	210	44
State Registra	r	31. Date field 8th 093 2	112	anny	egistrar's Signa	bare	1								

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		-	For State	State of Ma	aryland / I	Departm <i>Certific</i>				0.0	110	05750
			Registrar 1. Decedent's Name (First, Middle, Last	1) _ ($\overline{}$	Certino	ale of D		2. Date of Dea		11-6	3. Time of Death
	Physicia Medic		ALICE	()	AmA	250 N			Month	3 ⁱ	2012	0150 M
	Examin		4a. Facility Name (if not institution, give s Anne Arundel Me		ntor		city, Town, or Annapo	Location of Deat	n	4c. Count		undel
***************************************	Funeral		5. Social Security Number 6. Se		(In yrs. last bird		nder 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birt	h		place (State or Foreign
i i	Director		215-24-9209 Usual Residence of Decedent	□ M 2 X F	89	Yrs.	ns Days	Hours Will.	May 2		Mar	yland
	and show	ro	10a. State 10b. County		10c. City, Tow						1	0d. Inside City Limits
	Maryl 28a-f lotifie	irec	Maryland Anne A	cundel	Anna	polis						1 ☐ Yes 2X No
	vith the 23a or st be r	Funeral Director	10e. Street and Number 124 Conley Dr.			101	Zip Code 214	03		10g. Citizen of	What Cour SA	ntry?
	death v	Fune	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	ecedent of His	spanic Origin? (S	pecify Yes or No- o Rican, etc.)		ce - Americ	
36	after o	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 1 If Yes, Give	No		s 2 Xvo			Specify		lack
2-00	hours natura dical E	olete	15. Decedent's Ed (Specify only highest gra		16a	Decedent's t	Jsual Occupa	ition uring most of wo	rkina	16b. Kind of E	Business/In-	dustry
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	illed wi Il Hygie I other vent, ti	Be	17. Father's Name (First, Middle, Last)			00001			me (First, Middle,			
Maryland	Menta Menta narked	မ	John Jenkins					Mary V				
Mar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty) DeGora Johnson			•			_{iral Route Numbe} napolis			
re,	of Heal of Heal fitem		20a. Method of Disposition		20b. Place of	of Disposition ery, crematory	Name of		Date	20c. Location		
Baltimore,	. Page 1 tment of tant: If it jury or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	()		o Cre	mator	y 2-6	5-12	Balti		, Md.
Ba	permit, Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service License	ee e 10					ns Mort Annap	_		21401
		П	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused	the death. Do							Approximate Interval Between
~	Physician/		Immediate Cause (Final disease or condition	a	CUTE		PIRAT	URy.	FAILUR	E		Briset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequence		DUN	owi	FUMOR	MA		DAYS
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P.O. B	t the de by the stached	Phys	9 🗌 Unknown	9 Unknown		You take a considerable	:	on in Doct 1	00 8:11			he cause of death?
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Rec	sician: The law r certificate has b director, page 2 s	Completed								ormed?	death?	
ital	Physician: T r this certifica eral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	ace of Death (Che			(0	
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Division of Vital Records,	al or Al		4 ☐ Homicide determined	28e. Place of Inju building, etc		ami, street, ia	ctory, office		City or Tov		Jei or nura	noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medical Exami	sician: To the best of ner: On the basis of ex	kamination and/	or investigation	n, in my opinio	n, death occurred	at the time, date	and place, and d	ue to the ca	use(s) and manner stated.
	Fo the I within 2 Fo the I completed	M	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the	best of my kno	owledge, death	occurred at the 29c. License	number	place, and due to	the cause(s) and	manner as	Stated. Day Year)
	->		M chail,	1 He	war	w	D	21438		you	nary	2/40/
	30		30 Name and address of person who	mpleted cause of de	6 F . T	(Type Print)	ENSE	+ Hwy	ANA	AROU:	SMD	21401
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1	1	- (/			
	Registr	ar	FEB 0 3 2012	- Chama	1 B.	garla						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last 3. Time of Death Physician/ :50 PM Stevenson Februar Carol A. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 82 076-22-6668 Director 1 □ M 2 🛛 F Mar. 28,1929 New York Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2 X No Anne Arundel Severna Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 41 West McKinsey Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. "natural", 3 Widowed 4 X Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other the Education School Principal 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Lawrence Nathaniel Minnion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 360 State Street Apt 2222 New Haven, CT 06510 David Stevenson/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date , Department of I Important: If it any injury or o Feb. 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Inter the Msease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph. sician/ mentia Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death detached 1 L Yes 2 the P.O. I ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform eral Director: After this certificate in filled in by the funeral director, pag 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Spec Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 1,2012 1negs

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

8601 Veterans May

im.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

03 2012

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millersville, mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month SIMM Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death Examiner 4c. County of Death Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth Security Number **Funeral** Min 219-16-0570 88 **Director** 1 🗆 M 2 🗶 F July 21,1923 Maryland or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d, Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number r items 23a or ner must be n ö 10f. Zip Code 10g. Citizen of What Country? Funeral 904 Winding Way 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ian "natural", or iter Medical Examiner Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working ntal Hygiene.

ed other than "
event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname alth and Mental F 27 is marked of traumatic ever ၉ Mary Cecelia Lee Miller Antrim Almond McKay Page 1 and 2 should ! ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Simmons/Husband 904 Winding Way Salisbury, MD 21804 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 03, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Feb. Metro Crematory, INC. Baltimore, MD 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Ph_sician/ MIK disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying to (or as a consequence of, PROVED BY M or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown be detached the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>a</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe s after death.

Director: After this certificate! 2 No 2 X No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Montry, 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Natural 2 Accident MECHANICAL 2 **N**No filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Adults N City or Town, State) 4 Homicide determined within 24 hours a the Hospital Medical DIYI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who exampleted cause of death (Item 23a) (Type, Print)

State Registrar Catherine

FEB

31. Date filed (Month

Nelson

6 2012

Registrar's Signature

5. Greene

Baltimore, MD

21201

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 8:00 a M Veola Johnson Steward 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** ClintonNursing and Rehab. Prince George's Clinton 9. Birthplace (State or Foreign Country) AL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 8/29/1929 82 Director 050 24 3084 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No MD Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 20744 USA 10110 Griff Drive "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 Medical 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 f Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Seamstress 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bethlonia Brown Winston Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10110 GriffDr. Fort Washington, MD 20774 Mildred Y. Osborne/dtr 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗋 Burial 2 🖟 Cremation 3 🗀 Removal from State 2/9/2012 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Signature of Funeral Service Lice 2294 Old Washington Rd, Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PARUMONIA Physician/ disease or condition Medical resulting in death) ruence ot: Kidney disease (Stage 6) - Dialysis Examiner CHIONIC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: - nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 . No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, al Bleed, Cerebral tumos 1 Yes 2 No 3 Probably 4 Tonknown with metatastic disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

Registrar

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RXIndhuml

Stuart Lane,

2012

(Month, Day, Year FEB 0 6

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Razi Sindhwani Clinton, MD 20735

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		State of M	1arylano	_	artment of F tificate of E		and IVI		giene Reg. No	20	112	05756
Physicia	n/	1. Decedent's Nam			G 1			-		2. Date of De Month	ath		012	3. Time of Death
Medic Examine	al .			n Truman give street and number)	Swal	es ———	4b. City, Town, or	Location of		Januar	40	County	of Death	10:30P™
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Funeral Director		5. Social Security N 215 44 Usual Residence of	4296	6. Sex 1 ★ M 2 ☐ F	ge (In yrs. la 66	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 4 / 1 1 /		5	9. Birth	place (State or Foreign
land show d at	ğ	10a. State	10b. County			, Town or Lo							1	10d. Inside City Limits
Mary 28a-f)irec		St. Ma	ary's	L	eonar	dtown	<u>-</u>						1 X Yes 2 No
with the	eral	10e. Street and Nur 21585		dy Street			10f. Zip Code 2065	0			US. Cit		What Coul	ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 🔀 Never Marr 3 🗆 Widowed		12. Was Decedent Armed Forces' ied 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates.	?	1	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🛛 No	n, Mexican,	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Blac	e - Americ ck, White, Blac	
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permit. F Departm Importa any inju		21. Signature of Fu				- 22	2. Name and Addres	s of Facility	Bris	scoe-1	Coni	c F	uner	ral Home
Physician/		shock, or hea Immediate Cause	rt failure. List o (Final	complications that cause only one cause on each li					_					Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	on	a. Due to (or as	s a consequ		structo	n						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	at time of d	Ideath 3 📙	Ectopic pregnand Other (specify)						te of deliv	rery Day Year
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the Hosp hin 24 hou the Funer npleted fil	Medical	(Check 2 only one)	Medical E Certifying	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or inves	tigation, in my opinio death occurred at the	on, death oc e time, date	curred at t	the time, date	and place ne cause(s	, and du s) and ma	e to the ca anner as s	ause(s) and manner stated. tated.
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80,				who completed cause of Sec Olonu		23a) (Type, F SU 1+6	A 1	nopa	2ilc	am,	21	40	1	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2012 phryar acility Name (if not institution, air Town, or Location of Death unty of Death 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. 1 □ M 2 🕱 F Mir 107797 1918 22 5066 93 Yrs Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cecil Cecilton Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 Douglas Avenue 21913 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Midowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Clerk Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ringgold Joseph Mary Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Blackshire/Sister 26625 Bigwoods RD Worton, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date New Christian Chapel 2/18/12 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Worton, 22. Name and Address of Facility Bennie Signature of Funeral Service License Smith Funeral Home 855 High ST Chestertown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a knope Due to (or as a consequence of Sequentially list conditions. Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician Medical Examiner

Examine

Physician/Medical

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Certificate:

Medical

29b. Signature and title d

30. Name and address

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Physician/

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items 2

permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin

Baltimore, Maryland 21215-0036

72 hours after death

Examiner must be notified at

Director

Funeral

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Completed

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Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and physician attending the detached þ within 24 hours after death.

To the Funeral Director After this certificate has been signed I completed filled in by the funeral director, page 2 should be dete

Box 68760

Division of Vital Records, P.O.

if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 X Natural injury 2 No Accident Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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BROWN SI.

State Registrar

To the

MZ

1001

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ittiiew Schiilii	·9	1- For State Certificate of Department of F			g. No. 2012	0575				
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Matthew A. Schirling		2. Date of Deat Month February 1		3. Time of Death 0655 hrs				
		4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Dea		4c. County of Death					
Funeral			Westover If Under 1 Year If Under 24H	rs. 8. Date of Birt	Somerset h(MM/DD/YYYY) 9. Birt					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sha injury or ruther traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most	of working life. DO NOT use re Manager	etired)	Construct	ion				
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2121 uld be 1 Mental marke c event	To Be	Walter R. Schirling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac	ddress (Street and Number or	M. Evan		Zip Code)				
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Pem Dep Dep Inju		Jan J. L. Q M00295 116	73 Somerset Av	e. Princ	eral Home ess Anne, M					
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal of 4 Pregnant at time of death 5 Other	death 3 Ectopic pregr	nancy	1	ay Year				
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E 2 E 3	₩.	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)				
16L		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		February 2, 2012					
6	7.0	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore S	Street, Baltimore, MD 2	1223		il				
St	THE REAL PROPERTY.	31. Date filed (Month, Day, Year) FEB 1 0 2012 32. To trar's Signature	Kel							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf g925 3-7-12 vt. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	tificate of D	eath		Reg. No. 2	012	05759
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Richard Eugene Stine, Jr.				2. Date of De Februa	ry ^D 7,	2012	3. Time of Death 6:30 PM M
and the same	Examin		4a. Facility Name (if not institution, give street and number) 9187 Oak Tree Court		4b. City, Town, or Freder	Location of Deat	h	4c. Cou Fre	nty of Death derick	
*	Funeral Director		5. Social Security Number 217-42-9024 Subset of Decedent 4. Sex XXM 2 F 7. Age (In yrs. last XXM 2 F 8. Sex XXM	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da		Count	lace (State or Foreign try) yland
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rector		Town or Loc ederic					1	0d. Inside City Limits 1 ☐ Yes 2 1 No
		Funeral Director	10e. Street and Number 9187 Oak Tree Court		10f, Zip Code 21701			109. Citizen	of What Coun A •	try?
9036	urs after death ural", or items Il Examiner m	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 No If Yes, Give 1964-19	l If	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	E	Race - Americ Black, White, e	etc.
21215-0036	within 72 hou giene. er than "nati rthe Medica"	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	dent's Usual Occupa kind of work done do O NOT use retired) ice Offic	uring most of wo	rking		f Business/Inc	
Maryland	d be filed whental Hygarked otheric event.	To Be	17. Father's Name (First, Middle, Last) Richard E. Stine				_{me (First, Middle,} Margaret			
	d 2 should alth and 10 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Mrs. Linda # Stine, wife		ng Address (Street a Oak Tree					code)
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 ★ Surial 2 □ Cremation 3 □ Removal from State Cer 4 □ Donation 5 □ Other (Specify)	nce of Dispos metery, crem nt 01:	sition (Name of natory or other place ivet Ceme	tery Fe	Date b. 11m 2	20c. Locatio	on - City or To Freder	wn, State ick,MD
Balt	permit. Departi Import any inj		21. Signature of Feneral Service Limitee	.55 党	Name and Address eeney and 06 East C	f Bastor Church S	d PA Fur t., Free	neral H lerick,	ome MD 21	701
100	Physician/ Medical		23a. Part 1. Enter the disease, or complexitions that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque	Do not ente	er the mode of dying	, such as cardia	c or respiratory ar			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque							
	cate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c	ence of):					- 1	
8760	cate be e physicia s the bur	Medical	d							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal· 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	ý			Date of delive Month	ery Day Year
ds, P.O.	requires that the dea been signed by the a should be detached t		Part II. Other significant conditions contributing to death but not resul	Iting in the u	inderlying cause give	en in Part I.				ne cause of death?
Division of Vital Records,	ician: The law rec certificate has be rector, page 2 sho	Completed by	25. Was case referred to medical		00.5	(0, 1), (0)	1 Tes		b. Were autor prior to con death? 1 \(\sum \text{Yes}	osy findings available impletion of cause of 2 2 No
Vita	ysiciar is certii directo	To Be	examiner? 1 Yes 2 No 1 Inpatient 2 E	R/Outpatier	Otho	r: 4 Nursing	<i>еск only one)</i> Home 5 Ж Resi	dence 6 \square (Other (Specify)
on of	tending Ph Jeath. Ior: After th the funeral		27. Manner of Death 1 Natural 2 Natural 3 Pending 2 Accident Investigation	28b. Time of injury	work	103	28d. Describe			
Divisio	al or Attending s after death. Il Director: After ed in by the fune	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or Tou		mber or Rural	Route Number,
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowler (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my	and/or invest	tigation, in my opinio	n, death occurred	at the time, date	and place, and	due to the car	use(s) and manner stated.
رو	To the within comments of the		29b. Signature and title of certifier Mu	0 .	29c. License	number -33 7	9		ary 8,	
	101		30. Name and address of person who completed cause of death (Item 2 A. Zakaria Hegazi, M.D., 46	23a) (Type, P	rint) Mas Johns	on Dr.,	Frederi	ck, M	D 2170	2
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatu		barres					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan	•			Mental Hy	giene	010 05761
			1 - State Registrar	Cer	tificate of D	eath	-	Reg. No. 2	112 05/61
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	Day	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and number)	NO_	4b. City, Town, or	Location of Deat	THE		PO/2 J3/5 M Inty of Dea/th
	Examin	er		フ	Tak ma	2 Cocalion of Death	act	10. Coul	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bird	th	9. Birthplace (State or Foreign
	Director		008-56-5714	Yrs.	Months Days	Hours Min.	July 8	1953	Kenya
	nd at	ī	Usual Residence of Decedent 10a, State 10b. County 10c, Cit	ty, Town or Lo	cation				10d. Inside City Limits
	arylar la-fsl	Director		•					1 🏝 Yes 2 □ No
	the M or 28 e not	Dir	Maryland Montgomery Tak 10e. Street and Number	coma Pa	10f. Zip Code			10g. Citizen o	of What Country?
	s 23a sust b	Funeral	7520 Maple Avenue, Unit 107		20912			Kenya	
	be fled within 72 hours after death with the Maryland and Hygiene at Hygiene ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.s Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - American Indian, lack, White, etc.
36	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yes on Dates	1	☐ Yes 2 🗷 No	Specify:			ify: Black
9	hours natura ical E	Completed	15. Decedent's Education		fent's Usual Occupa				Business Industry
215	n 72 l e. ian "r Med	щ	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	kind of work done d O NOT use retired)	uring most of wo	rking		
2	l withi ygiene her th		4	Hospi	tal Trans				tal Services
Maryland 21215-0036	e filed ital Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)				me (First, Middle,		me)
Z	should be fill and Mental is marked raumatic eve	Г	Stephen Savano Maveke 19a. Informant's Name/Relationship (Type, Print)	T			anini Sa		0.1.7.0.1.
Ma	2 shouth and the and the street t		Thomas Kombo/Friend		ng Address (Street a				Maryland 20871
ē,	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The mand Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. F	Place of Dispo	sition (Name of		Date		n - City or Town, State
Baltimore,			Burlai 2 Gremation 3 La hemova nom state	cemetery, cren engani	natory or other place		8/2012	Kenya	
a E	permit. Page Department Important: I any injury or once.		21. Sig_ ture of Funeral Service Licensee	22	. Name and Addres	s of Facility Mc	Guire Fu	meral:	Service, Inc.
m	a m m		Palbre N. Obant	74 Wa	00 Georgi	la Avenu Distric	e, North t of Col	west umbia	20012
			23a. Part 1. Enter the disease, of eemplications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between
P	hysician	0.7	Immediate Cause (Final disease or condition	SIVY	Cara	10 VAS	1 Vi	7.	set and Death
	Medical Examiner		resulting in death) a. D./ (f (or as a consequence)	uence of):					
		er	Seque tially flet on allower, if any, leading to immediate Due to (or as a consequence of the control of the co	mence of:					_
		Examiner	cause. Enter Underlying Cause (Disease or iinjury	deriod diji					
	n and	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence)	uence of):					
00	death certificate be executed he attending physician and ed for use as the burial-fansit.	dical	d						
6876	tificat ng ph as th	Mec	IF FEMALE:						
9 ×	th cer Itendi or use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 Live Birth 2 Feti	tal death 3 🛚	Ectopic pregnancy	у			Date of delivery Month Day Year
Box	e dear the at hed fo	ysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown 9 Unknown	death 5 ∟	Other (specify)			l "	north bay real
P.O.	requires that the death certifical been signed by the attending p should be detached for use as t	/ Ph	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to the cause of death?
Ś.	sign Id be	q p	myasthenia zrav	15			1 🗆	Yes 2 □ No	3 ☐ Probably 4 Unknown
ord	v requ	olete					24a. Was		o. Were autopsy findings available
Division of Vital Records,	sician: The law is certificate has be lirector, page 2 s	Completed by					autop perfo	osy ormed? 2 A No	prior to completion of cause of death? 1 Yes 2 No
a .	ian: I	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Che		2,40110	12 100 22310
5	hysic his ce I direc	10	1 Yes 2 No 1 Inpatient 2			r: 4 🗌 Nursing l	Home 5 Resid	dence 6 🗆 O	ther (Specify)
ָס ל	ing P	ate:	27. Manner of Death 28a, Date of injury (Month, Day, Year) 28 (Month, Day, Year)	28b. Time of injury	work	?	28d. Describe h	now injury occu	ırred
Sior	death death ctor: / the 1	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Usersigide 28e. Place of Injury - At ho	ome farm str		Yes 2 No	28f Location /	Street and Num	nber or Rural Route Number,
N N	lor A after Direc		4 Homicide determined building, etc. (Specifi	<i>y)</i>	oct, ractory, office		City or Tou		iber of Harar Floate Namber,
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physician: To the best of my know						
	the Hi nin 24 the Fu nplete	Mec	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m		death occurred at the	time, date and pl			
	With Control		29b. Signature and title of certifier		29c. License	/ . 0		29d. Date sign	ned (Month, Day, Year)
	,		bou 2) secher wo		E DOE	/	1	Jeb	1, 2012
			30. Name and address of person who completed cause of death (Iten	n 23a) (Type, F	Print) 52	yman	4460	0.7	D andrik
	Sta	e í	31. Date filed (Month, Day, Year) 32. Registrar's Signa	atere.	12	NVCF	Pri	10 10	U 2070T
	Registra	ar	FEB 07 2012 Cerus A	2. 194	Name:				

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State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Registrar		rtment of H tificate of D			Reg. No. 20	12	05762
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	Cto	10:01		2. Date of Dea Month	Day	Year	3. Time of Death
	Medic	cal.	Muriam 4a. Facility Name (if not institution, give street and number)	Ster	4b. City, Town, or	Leasting of Dooth	Januar	y 29, 2		6:02 P M
	Examir	ner		7.	Rockvi]		1	Mont		~17
4	Funeral	_	Potomac Valley Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last b)	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		106-22-0168 1 □ M 2 X F 83	Yrs.	Months Days	Hours Min.	(Month, Day		Coun	**
	od at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation		pcrober	20,1920		oklyn, NY 10d. Inside City Limits
	arylar a-f sk fied a	윦	DC Distric of Columbia Washi						- 1	1 ☐ Yes 2 😿 No
	or 28	ä	10e. Street and Number	Ingro	10f. Zip Code			10g. Citizen of \	What Cour	
	with t	Funeral Director	3243 Military Road NW		20015			United	State	25
	death items ier mi	Full	11. Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp		14. Rac	e - Americ	can Indian,
036	s after or ral", or Examin	ed by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes 2X No		Triodii, ctc.)	1	Cauc	etc. Casian
21215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed		(Give ki	ent's Usual Occupa ind of work done do NOT use retired)		king	16b. Kind of B	usiness/In	dustry
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פַ	filed within tal Hygiene d other the event, the	Be	17. Father's Name (First, Middle, Last)	O			ne (First, Middle,			-
Maryland	d be d Menta arked	မ	Jacob Frank			Sophie :	Lobe1			
lan	should and is is ma				Address (Street a					Code)
_	of Health and Mental F of Health and Mental F fitem 27 is marked o r other traumatic eve				Military	Road NW	, Washin			0015
or e			1 Burial 2 X Cremation 3 Removal from State cemer	tery, crema	ition (Name of atory or other place		Date	20c. Location -	•	
Baltimore,	permit. Page Department Important: I any injury o			_	ln Cremat		/2012 Simple T		od, N	Maryland
g	Department once		21. Signature of Funeral Service Licensee M01102	- 1	Name and Address 40 Rockvi		-		ary1a	and 20852
ı		Г	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
gartin.	Ph __ sician/		Immediate Cause (Final disease or condition Complications	of CO	OPD (Chron	nic Obst	ructive	Pulmona	rv	Onset and Death 5 years
	Medical Examiner		resulting in death) Due to (or as a consequence				Disease)		
		ē	Sequentially list conditions, if any, leading to immediate b.						_	
	B 1	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o on						
	xecut al-	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence	e of):					+	
	ficate be executed g physician and as the burial-	edical	d							
2/60	ificate ig phy as th		IE EEMALE.							
χ ×	h cert tendin ir use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	ath 3 🗆	Ectopic pregnancy	/			te of delive	*
POX	e deat the at thed fo	Physician/N	1 Yes 2 No 4 Pregnant at time of death	1 5 🗌	Other (specify)			Mo	nth	Day Year
J.	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to th	ne cause of death?
S	uires t n sign uld be	ed by					1 🗆 ۱	Yes 2 X No	3 🗆 Prol	bably 4 🗆 Unknown
Vital Records,	w req s bee 2 shor	Completed					24a. Was a		Vere auto	psy findings available mpletion of cause of
Ç	The la	mo.					autop perfor	rmed?	death?	_
TO.	ian; ertifica ctor,	Be C	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec				
5	hysic his ce al dire	은	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O			4 A Nursing H	ome 5 Resid	ence 6 🗆 Othe	r (Specify)
101	ling P 1. After t funera	ate:	1 X Natural 5 ☐ Pending (Month, Day, Year)	. Time of injury	28c. Injury work?	?	28d. Describe h	ow injury occurre	ed .	
	death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Description	farm stree		Yes 2 □ No	28f Location /S	treet and Numbe	ar or Pumi	Poute Number
UNISION	al or A s after I Direct d in b		4 Homicide determined building, etc. (Specify)	iaiiii, otiot	st, lastory, omos		City or Tow		T OF Flura	moute Number,
_	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use a specific page.	ledical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	d/or investig	gation, in my opinior	n, death occurred a	at the time, date a	nd place, and due	to the cal	use(s) and manner stated.
	o the	ž	only one) 3 X Certifying Nurse Practitioner: To the best of my kn 29b. Signature and title of certifier	nowledge, o	death occurred at th			ne cause(s) and m		
			Land Nime Col	D	125562			2/11	20	12
			30. Name and address of person who completed cause of death (Item 23a)) (Type, Pri		() I D		711	210	10
			Tyree Morison, 1235 Potomac Valle		ŕ	ville, M	aryland	20850		
	Stat		31. Date filed (Month, Day, Year) 2. Registrar's Signature	bas	20					
	Registra	ar	FEB 06 2012 German B. 1	7						

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For	State of Maryland / Department of Healt
State	Certificate of Deat

		For State Registrar		State	ot Marylan		irtment of H tificate of D		ia ivieni		ene g. No.		
Physicia	n/	Decedent's Name (F	irst, Middle,	,						ate of Death	1	Year	3. Time of Death
Medic	al	Madelynn 4a. Facility Name (if no	Loui		avounos		4b, City, Town, or	Landia of D		oruary	7		11:30aM
Examin	er	17501 New					Asht		Jean		4c. County Mont	gome:	ry
Funeral		5. Social Security Num		6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 I Hours N		ate of Birth Month, Day,	Year)	9. Birthp	lace (State or Foreign
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a lmportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show a lmy injury or other traumatic event, the Medical Examiner must be notified at once.		216-64-32 Usual Residence of D		1 □ M 2 🖾 F	56	Yrs.			Ser	ot. 30	, 1955	Wash	ington, DC
	tor	10a. State 10	0b. County		10c. City	, Town or Loc	ation					1	0d. Inside City Limits
Many 28a-i	Funeral Director	MD		gomery		Ashto							1 Yes 2 No
vith the	ral	17501 North		hima Arra			10f. Zip Code 20861			10	0 <i>g.</i> Citizen of V USA	Vhat Coun	try?
eath w	Fune	17501 New	пашра	12. Was Dece	edent Ever in U.S	S. 13. V	as Decedent of His	spanic Origin?	? (Specify Y	es or No-	14. Race	e - America	
after d ", or i camin	by	1 Never Married		ed Armed Fo	2 🔀 No		Yes, specify Cubar ☐ Yes 2 🖾 No		чепо кісап	, etc.)		k, White, 6 Whit 6	
nours a	To Be Completed		15. Deceden	Year or Date of the Year or Date of The Year o		16a. Deced	ent's Usual Occupa	ation		1	16b. Kind of Bu		
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be file ental F ked o ic eve		John Hora		ist)				Regin			alden Surname)	
should and M is mar aumat		19a. Informant's Name				19b. Mailin	g Address (Street a	nd Number or	r Rural Rout	te Number, C	City or Town, S	tate, Zip C	ode)
and 2 stealth		John Sclav		/Husband			New Ham						
ige 1 and of Fite If ite		20a. Method of Dispos	Cremation	3 Removal from	State	emetery, crem	sition (Name of atory or other place	F	eb. 9	,	20c. Location -		
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Depar Depar Impo any ir		1 Can	<u></u>	200	De	F	rancis J. 00 Univer	Colli sity B	ns Fu Blvd.	neral W., S:	Home I ilver S	nc. prin	g,MD 20901
			ailure. List or	complications that only one cause on ea	caused the cath ach line.	n. Do not ente	r the mode of dying	g, such as card	diac or resp	iratory arres	t,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Fin disease or condition resulting in death)	al	a. Anore									Onset and Death
Examiner					oras a consequ		zheimer's	Tyne				7-	⊦ years
_ =	edical Examiner	Sequentially list condi if any, leading to imme cause, Enter Underlying	ediate		(or as a consequ			1/20					
ficate be executed g physician and as the burial feature.	≅xaπ	Cause (Disease or injuthat initiated events resulting in death) Las		c	(or as a consequ	ence of):							
be ex sician buria	cal	resulting the areathy and		d	,	,							
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ne dea / the a ched f	Physician/N	1 Yes 2 X N		4 ∐ Preg g ☐ Unki	mant at time of d nown	leath 5 L	Other (specify)				Wich		Day Teal
that the ned by e deta	by Pł	Part II. Other significa	ant condition	ns contributing to d	leath but not res	ulting in the u	nderlying cause giv	en in Part I.	2	23e. Did toba	acco use contr	ibute to th	e cause of death?
quires en sig ould b	ted									1 🗌 Yes	s 2X No	3 🗌 Prob	ably 4 🗌 Unknown
law re has be le 2 sh	Completed							···	2	24a. Was an autopsy perform	/ F	Vere autop prior to cor leath?	sy findin <i>g</i> s available npletion of cause of
n: The ficate I or, pag	e Cor	25, Was case referred	to medical				00 Di-			1 🗌 Yes 2	⊠ No 1	Yes	2 🗆 No
ysicial s certi directe	To Be	examiner?		Hospital:	Inpatient 2	ER/Outpatien	Othe	r: 4 Nursir			nce 6 🗆 Othe	er (Specify)	
ng Phy fter thi uneral		27. Manner of Death	5 Pending	28a. Date		28b. Time of injury	28c. Injury work	at			v injury occurre		
ttendi death. stor: A y the fi	Certificate:	2 Accident 3 Suicide	Investig	ation ot be	of Injuny - At ho	me farm etre	M 1 1	Yes 2 No		anation Ctra	not and Mumbe	or Pural	Pouto Numbor
al or A s after l Direct		4 ☐ Homicide	determi		ng, etc. (Specify,		et, lactory, office			City or Town,		i oi nuiai	Route Number,
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 X	Certifying Medical F	Physician: To the base	est of my knowless of examination	edge, death o	ccurred at the time	, date and pla	ace, and due	e to the caus	se(s) and mann	er as state	ed. se(s) and manner stated
the Fithin 24	Me		Certifying	Nurse Practitioner				ne time, date a		nd due to the		anner as s	tated.
0		▶ (\ \	MX)	MIN				56293			ebruary		
		30. Name and address					rint)					,	
		Chiadi On	yike,	MD 60	00 N. Wo	lfe St	reet, Bal	ltimore	e, MD	21287			

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year) **FEB 0 8 2012**

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Stat Registra	e	31. Date filed (Month E.B. 2 any 2012 34 Registra	leath (Item 23a) (Type, P	Med	, , ,	. 10		
	7		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, P			21740)	
	5 wit So⊔os		29b. Signature and title of certifier \$\mathbb{H}\$ \$\mathbb{H}\$ \$0\$		29c. License			3d. Date signed (/ クタ / 1 4 / 。	Month, Day, Year)
	the Hos hin 24 hc the Fune	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practitioner: To the	examination and/or invest	igation, in my opinio death occurred at th	n, death occurred and p	at the time, date and lace, and due to the	l place, and due to cause(s) and mar	o the cause(s) and manner stated. nner as stated.
Divisi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		4 Homicide determined 28e. Place of Inju-				City or Town,	State)	or Rural Route Number,
Division of Vital Records, P.O.	tending F leath. or: After t the funera	Certificate:	27. Manner of Death Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	y, Year) injury	M 1 🗆	yat ? Yes 2 ☐ No	28d. Describe ho	v injury occurred	
f Vita	ding Physician: The law h. After this certificate has funeral director, page 2	: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpati	ient 2 ER/Outpatien	nt 3 🗆 DOA Othe	er: 4 🗌 Nursing H	ome 5 Reside		(Specify)
al Re	an: The Is ifficate his tor, page		25. Was case referred to medical		26 Pla	ace of Death (Chec	perform 1 Yes 2	ned?/ de	ath? ☐ Yes 2 ☐ No
cords	aw requir as been s 2 should	Completed					24a. Was ar autops	24b. We	ere autopsy findings available or to completion of cause of
, P.O	es that the signed by	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did tob		ute to the cause of death?
. Box 68760	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown 9 Unknown	2 Fetal death 3 E	Ectopic pregnanc Other (specify)	у		23d. Date Mont	·
38760	ertificate ling phys se as the	/Medical	IF FEMALE:	of programmy					
_	icate be executed physician and is the burial-transit		that initiated events resulting in death) Last	a consequence of):					
	ted 1	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence cry:					
	Medical Examiner		resulting in death) a. Due to (or as	a consequence of):					10,12,102,103
ينفر	Ph_sician/		23a. Part 1. Enter the disease, or combilications that caused shock, or heart failure. List only one cause on each lind immediate Cause (Final disease or condition	d the death. Do not ente e.	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Ba	Depar Depar Impo any ir		21. Signature of Funeral Service Licensee	16	2. Name and Addres	ylvania .	Ave., Hag	gerstown	
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren Smithsbur	natory or other place cremat	ory 2/1	5/2012	Smithsb	urg, MD
re, M	and 2 sl Health a tem 27 is		Donna M. Spielman/Wife 20a. Method of Disposition		25 Pleasa		Or., Hage	rstown,	MD 21740 Dity or Town, State
aryla	hould be and Ment s marke umatic	은	Donald Richard Spielman 19a. Informant's Name/Relationship (Type, Print)	19b. Mailiu	ng Address (Street a		Carmelet		
nd 21	filed wit al Hygier d other i	Be	17. Father's Name (First, Middle, Last)	Poli	ce Office		ne (First, Middle, M		overnment
1215-	hin 72 hc ne. t han "na e Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+	(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	during most of wor	king	16b. Kind of Bus	
Maryland 21215-0036	ours after tural", or al Exami	ted by	1 ☐ Never Married 2 ፟፟ Married 1		1 ☐ Yes 2 🔣 No			Specify:	White
	death w items?	Funeral	10025 Pleasant View Drive 11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. \	Was Decedent of Hill Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
	ith the N 23a or 2 at be no		10e. Street and Number		10f. Zip Code	0		0g. Citizen of Wh	·
	Marylar 28a-f sh etified a	Director	MD Washington	Hagersto					1 ☐ Yes 2 🎇 No
		١	Usual Residence of Decedent 10a, State 10b, County	57 Yrs.	cation		Sept. 2	6,1954	Maryland 10d. Inside City Limits
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Ag 213-68-5915 1 ☒ M 2 ☐ F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
- Complete	Examir	er	4a. Facility Name (if not institution, give street and number) 10025 Pleasant View Dr.		4b. City, Town, or Hagers	r Location of Deatl Lown	1	4c. County o	f Death ington
ı	Physicia Medic		Gary Keith Spiel	.man			Month Februar	Day	3. Time of Death Year 09:50 A
			State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Death	2. Date of Deat	eg. No. U	, 00,0.
				laryland / Depa			Mental Hyg	iene	12 05764

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Month F E B HI LDA IRENE SNYDER 3:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAMSPORT NURSING HOME WASHINGTON WILLIAMSPORT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 M 2 X (Month, Day, Year, 9/1/1919) 92 Hours 215-18-2603 MARYLAND **Director** Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland traumatic event, the Medical Examiner must be notified at Director WILLIAMSPORT WASHINGTON 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 EAST VILLAGE LANE Funeral 21795 USA items within 72 hours after death Was Decedent Ever in U.S . Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married ō 2 XNo ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes. Give than "natural", 3 🗌 Widowed 4 🗌 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) f Health and Mental Hygiene. Item 27 is marked other tha SECRETARY HOSPITAL 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ HARRY G. SNYDER IRENE BLOYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 E. HILLCREST RD. #2, HAGERSTOWN, MD 21742 STEVEN SNYDER/NEPHEW Place of Disposition (Name of cemetery, crematory or other place)
 ST. PAUL'S CEMETERY 20a. Method of Disposition . 17, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLEAR SPRING, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ KILLI CEREBRAL ARIEK THROWBOSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Yes 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? certificate 2 No 2 X No Yes Hospital or Attending Physician: nin 24 hours after death.

the Funeral Director: After this certific

inpleted filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

2v

ARTICAN ST

WILLIAMSPORT

21795

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howe

31. Date filed (Month, Day, Year,

N,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Michael J. Schatzei	Sta 1- For State Registrar	ate of Maryland / De _l <i>C</i>	partment of Health a fe <i>rtificate of Death</i>	and Mental Hyg	giene Reg. No	2012	0576
Physician/ Medical Examiner	1. Decedent's Name (First, Middle		Schotzer		Date of Death Month Day	Year	3. Time of Death 0726 hrs
Magaical Examine	4a. Facility Name (if not institution	J . n, give street and number)	Schatzer 4b. City, Town	, or Location of Death	February 10, 2	c. County of Death	
	11711 Livingston Road		Fort Was			Prince George	
Funeral Director	227-31-4941	6. Sex 7. Age (In yrs	S. last birthday) () () () () () () () () ()		8. Date of Birth(MN 04/19/19	Foreig	
any	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once. ector		e George's F	t. Washington				1 Yes 2XXXIIo
h the Maryland 3a or 28a-f sh totified at once		on Lane	10f. Zip Coc 2074	44		tizen of What Cour USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked refer than "natural", ur items 23a or 28s-f-sho injury nr other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 XXMa	1 Yes 2 No	If Yes, specify Cu	Hispanic Origin? (Speciban, Mexican, Puerto Ri		White, etc.	can Indian, Black, hite
urs afte		orced If Yes, Give Year or Dates: ify only highest grade completed)		upation (Give kind of wor		Specify: WI Kind of Business/li	
5-0036 ed within 72 houri lygiene. inther than "natu he Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. DO NOT use retired		HVAC	
-003 I within giene. ther th	17. Father's Name (First, Middle,	4 years	Project Fore	eman 18.Mother's Name (F			
MD 21215-0036 td 2 should be filed within 7 thin and Mental Hyggene. In 27 is marked uther than anmatic event, the Medical TO Be Comple		natzer		Jean	Cauld	well	
D 21 should and Me	19a. Informant's Name/Relationsh		19b. Mailing Address (S				
e, MI	Ann C. Schatzer 20a. Method of Disposition	20	b. Place of Disposition (Name of	guson Lane I	Date 20c	ngton, Mil. Location - City or	0 20744 Town, State
Baltimore, permit. Pages I ar Department of Heg Important: If Ite	1 X Burial 2 Cremation 4 Donation 5 Other Society 21. Signature of Funeral Service I	ecify:	crematory or other place) edar Hill Cemet	cery 02/10			, Maryland
Depart Injury	Ph P. Ks	c	6160 0xc	on Hill Rd.	Oxon Hil	l, Maryla	and 20745
Physician ृ/Medical Examiner	23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease)			ing, such as cardiac or r	espiratory arrest, sh	nock, or heart	Approximate Interval Between Onset and Death
LAGIIIIICI	or condition resulting in death)	Due to (or as a consequence	e of):	10			
O, sician and burial - transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence					
d d ansit	events resulting in death) Last	Due to (or as a consequence d.	e of):				
oe execcian an inial - tr	X UNPENDED	\square AMENDED $23a, 27$,	28a-f,per me,g	925 3-1-12	sm		
3760, ficate be g physicist the buri	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pr		3 Ectopic pregnanc		3d. Date of delivery Month	lay Year
be death certificate be executed the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	past 12 months?	4 Pregnant at time of	2		<u>"</u>	World D	ay rou
Division of Vital Records, P.O. Box 6876 tal or Attending Physician: The law requires that the death certificat is after death. *I Director: After this certificate has been signed by the attending phicel in by the funeral director, page 2 should be detached for use as the artification: To Be Completed by Physician/M		ons contributing to death but no	ot resulting in the underlying cau	se given in Part I.			the cause of death? ably 4 Unknown
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Reco					performed?		s 2 No
ital Rec niclan: The s certificate lirector, page Be Con	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	_	Other Nursing	ly one) Home 5 Resid	lence 6 🗸 Other	Scene
n of Viding Physical After this funeral dim	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)			8d. Describe how in		Costio
ion ftendir feath. tror: A / the fu	1 Natural 5 Pendi 2 Accident Invest		fd 0644 hrs ^{1[}		nknown		
Division o apital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X Could 4 Homicide	I not be mined (Specify) reside	t home, farm, street, factory, offi		Bf. Location (Street or Town, State) ort Wash:	1614 Ferg	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phyrician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier (Check only) Certifying Ph	ysician: To the best of my knowledge. niner:On the basis of examination and manner stated.	edge, death occurred at the time	e, date and place, and du	ue to the cause(s) a	nd manner as state	
F > F 3 S	29b. Signature and title of certifier		1 1	ense number C.M.E.	i _	Date signed (Morber 11, 201)	
6	30. Name and address of person of Zabiullah Ali, M.D.	who completed cause of death (Ite Assistant Medical Examin		treet. Baltimore M	1D 21223		
State		32. Registrar's Sign				•••	
Registrar	<u> </u>	2012 Jenewa	p. March			UCIAE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ Jane T. Thomas 19:45M Feb 2013 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Georges Hospital Cheverly Prince George's Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 1 M 2 🕮 F Hours 1929Washington, DC 577-48-5694 Director Feb Usual Residence of Decedent shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sk notified a 1 1 Yes 2 □ No Washington DC None 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 1235 Chaplin St., 20019 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Black 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates "natural", 3 🖾 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Private æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of ည Tue 11 William Spencer traumatic 19a. Informant's Name/Relationship (Type, Print) (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1371 Sheridan St., NW Washington, DC 20011 Wanda Lucas Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Chesapeake Crem. 1 Burial 2 Cremation 3 Removal from State Beltsville, MD 4 Donation 5 Other (Specify) 2-9-2012 22. Name and Address of Facility 5732 GA., Ave. NW Wash. DC Genesis CremationAnd Funeral Serv. 20011 22. Name and Address of Facility 5 7 3 2 Signature of Funeral Service Licenses Francine Bryant 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **hysician** lar + Subarachnow disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has or Attending Physician: The law autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 Yes Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Configure Pranticiners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Configure Pranticiners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Configure Pranticiners To the best of my knowledge. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 20047183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. D. te filed (Month, Day, ear) 2. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar					Certific	ate of	Death					Reg. No.				
Physic dical Exam		1. Decedent's Nan			nison							*	2. Date of Dea Month February	Day	Year	ŗ	3. Time of Death 1700 hrs	ı
		4a. Facility Name 40880 Mea			treet and n	ımber)		41	c. City, To Leona		ocation of	Death			c. County o			
Funeral Director		5. Social Security		6. Sex		5.00		last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.				24Hrs.		,		Foreign		
Director		220-74-2140 1½ M 2 F 54					4	Yrs.					03/16)/19	5 /	Cou	ntry) MD	
4 811		10a. State	10b. County				City, Town										10d. Inside City I	
Maryland 28a-f show datonce.	ctor	MD 10e, Street and Nu	St. N	lary'	S		Leona	rdtow	71). 10f. Zip (Code				10a. Citi	izen of Wh	at Coun	1 Yes 2 trv?	ÃNo
the Ma a or 28	Director	40880 Me		rive					2065						ed St			
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	Funeral	11. Marital Status 1 Never Marr		1	2. Was Dec	orces?			Deceden	t of Hispa			cify Yes or N Rican, etc.)		_	- Americ	an Indian, Black,	,
P 5 8	正	3 Widowed		vorced If	1 Yes Yes, Give Yes r Dates:	2 X	No	1 .	Yes 2	No	specify:				Specify:	Whi	:e	
2 hours after "natural".	ted by	15. Decedent's E Elementary/Sec		cify only	highest gra		ed) 16a.	Decedent's during mos						10	Kind of Bus		dustry	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Intel: Witem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	12	ondary (0-12)		College (1-4 () ()+)		Forem	an						lectr ooper		7e	
5-00 led wit Hygien other	🞖	17. Father's Name	(First, Middle	, Last)						18	3.Mother's	Name (First, Middle,	Maiden	Surname)			
d be filental	B B	James Lo											Coyne					
D 2 shoul and M 7 is m	₽	19a. Informant's N				£.		•					ıral Route Nu				Zip Code)	
Baltimore, MD 21215-0 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygin Important: If item 27 is marked othe injury or other traumatic event, the I		Kathleer 20a. Method of Dis		nnıs	on/wi		20b. Place o	of Disposit	on (Name	e of ceme	eterv.		nardtow Date				own, State	
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Physician		23a, Part I. Enter to	he disease, o	complica	ations that o												Approximate Int	
IMedical Examiner		Immediate Cause	(Final disease	0		otgun W	ound of	Chest									Death	,
		or condition result	3	Du- b.	e to (or as a	conseque	nce of):											
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ed nsit	Examiner	(Disease or injury events resulting in		Du	e to (or as a	conseque	nce of):											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dramath physician. The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED)	d	AMENDED						٠							
rificate be ing physici as the buri	/Me	IF FEMALE: 23b. Was decedent	pregnant in t	ne		outcome of	pregnancy	Feta	l doath	3 [Ectopic	pregnan	CV	23	d. Date of o	delivery D:	ay Year	
Box 68 se death certi the attending	sicial	past 12 month		known	4 Pregr	ant at time			er (Speci		Lotopio	program			Wichian		ay roan	
D. B. the de by the	Phy	Part II. Other sign			9 Unknontributing to		not resulting	g in the un	derlying o	ause giv	en in Pari	t I.	23e. Did t	obacco	use contrib	bute to t	ne cause of death	1?
v requires that the speen signed by should be detach	d by												1 Ye	s 2 💽	/ No 3	Proba	ably 4 Unkno	own
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Vital ysician: his certifi director,	B	25. Was case reference examiner?			pital:	Inpatient	2 FR/0	utpatient		10	f Death (0 ther ₄			D:4-	ence 6 🗸	ē 0#		
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Division of Vital Records, pital and attending Physician: The law requiremental after death. In law certain After this certificate has been sittled in by the funeral director, page 2 should t	Certific	3 Suicide	6 Cou	ld not be	1	e of Injury - resider	At home, fa	arm, street,	factory, o	office bui	lding, etc.		28f. Location (or Town, 5 0880 Meado	State)			al Route Number,	, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 29a, Certifier (Check only			: To the be:	st of my kno	wledge, dea					e, and d	lue to the cau	se(s) ar	nd manner	as state	d.	
To the Ho within 24 h To the Fur	ledical		Medical Exa	ar	n the basis nd manner s	of examinat tated.	tion and/or i	nvestigatio				urred at	the time, date					
	Σ	29b. Signature and	a ditie of certific	eri	20	0.				License i					Date signe oruary 14		th, Day,Year) 2	
		30. Name and add	ress of persor	who con	npleted cau	se of death	(Item 23a)											
) RML		Patricia Arc			•			iner 9	00 W.	Baltimo	ore Stre	eet, Ba	altimore, M	ID 212	223			
	tate	31. Date filed (Mon	nth, Day, Year)	0044	32. K	egistrar's Si	gnature	has					_					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2:02 p Tucker John Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0202 ריטדמי Social Security Number Sex 1 X M 2 ☐ F 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Yea Director 083-30ew Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or from not any injury or other frammer. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND Trince inton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10202 USA 20735 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 🗷 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervis 1405p! Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗖 Burial 2 🗆 Cremation 3 🗆 Removal from State MARL 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility 20608 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician cian/Medical Division of Vital Records, P.O. Box 68760 the l use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Pregnant at time of death Other (specify) Month Day Year Physic 2 No the 9 Unknown 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 e and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year)

State Registrar and address b

31. Date filed (Mont)

erma

Center Drive Suite

20170

+ MO

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 20**1**2 5:20 p м Gloria Belle Todd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Months Min. 1 🗆 M 2 😾 F Maryland Director 220-26-8888 80 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director items 23a or 28a-f MD Dorchester 1 ¥ Yes 2 ☐ No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 518 Glenburn Ave., Apt. 202 USA 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No 1 Yes 2 No Specify: Specify: white Completed 3 Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) crab picker seafood 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. G. Adams Modia Revnolds 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald C. Todd husband 518 Glenburn Ave., Apt. 202, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 2/10/12 Cambridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Thomas Funeral Home P.A. 700 Locust St. Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ dementia 16015 disease or condition Medical resulting in death) Due to (or as a consequence of) vascular disease Examiner 2thlevo scientic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy death? Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 ♣ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of To the Hospital or Attending Pr within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

68760

Box

100 Bramble

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

500

32. Registrar's Sinature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY Day Physician/ 8 28/2 2050M SUSIE DEMEYERS TODD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Camer I DGE DORCHESTER DOCCHESTER ENPRAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days JULY 8, 1923 1 M 2 X F 88 NEW YORK 091-14-7712 Director Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No MARYLAND DORCHESTER SECRETARY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 150 MAIN STREET 21664 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE 3 XWidowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. OWN HOME 11 HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) CORA TIMMERMAN JACOB DEMEYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Healtness
Important: If item 27 is DENNIS G. TODD/SON O. BOX 250, EAST NEW MARKET, MARYLAND 21631 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State EAST NEW MARKET CEM. 2/12/2012 EAST NEW MARKET, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
ZELLER FUNERAL HOME, P. O.
LOG MAIN STREET, EAST NEW 21. Signature of Fyneral Service Alcense Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit henic Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 We 욘 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: After Completed filled in by the fune. 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

State Registrar wh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 02/01/2012 HOWARD LEE THOMPSON, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>13918 Parkland Drive</u> Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 11/18/1920 Director 578-26-4721 91 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20853 13918 Parkland Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 1X Yes 2 If Yes, Give 2 No 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Hygiene. Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Medical Center Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harriet R. Swailes Samuel Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Pullman Court, Mt. Airy, MD 21771 Deborah Thompson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 02/09/2012 Silver Spring, MD 4 Donation 5 Other (Specify) Gater of Heaven Cem. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 Weeks Physician/ Strake disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, End stage renal disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No page 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 XNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 2 No 2 Accident 3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

3. Time of Death

10d. Inside City Limits

Interval Between

29d. Date signed (Month, Day, Year) 02/02/2012

1 ☐ Yes 2X No

1:00 P M

To the Hospital or Attending Physician: thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun within 2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and t ddess of person who completed cause of death (Item 23a) (Type, Print)

3941 Ferrara Drive, Wheaton, MD 20906

1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D21340

Raymond Bass, 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check

Medical

Registrar's Signature

Registrar

Registrar

DHMH 17 Rev 7/2009

State

Rd

Montrose

Rockville MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli, MD

FEB 08 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 Virts 5:00 p^{M} Randolph Stuart Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Brooke Grove Rehab. and Nursing Ctr. Sandy Spring Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months 579-22-9167 Director 1**X** M 2 □ F 91 Dec. 6, 1920 VA Usual Residence of Deced show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1 Yes 2 X No MD Montgomery Silver Spring 5 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 3418 Chiswick Court 20906 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes Ž No Specify: If Yes, Give WWII Year or Dates. "natural" 3 ^X Widowed 4 □ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than "r

r traumatic event, the Med Elementary/Secondary (0-12) College (1-4-9r 5+) Manager Life Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William E. Virts Henrietta Elizabeth Perry-Ascough 19a. Informant's Name/Relationship (Type, Print) - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Elizabeth Randolph Virts 3418 Chiswick Court, Silver Spring, MD 20906 other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State c If P Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Feb. 6, 2012 Department of Important: If any injury or ò 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licensee MD 20001 500 University Blvd. W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Congestive Heart Failure disease or condition Medical resulting in death) **Examiner** Stroke Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed use as the buria, tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Por in the past 12 months? Month Dav Year detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, Hypertension, Hypercholesterol, Bladder Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown plnods peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work?
1 Yes 2 No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar

29b. Signature a

title of certifie

Anuradha Arun, MD

FEB 07 2012

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

15+1

barres

14120057630

10301 Georgia Avenue, #209, Silver Spring, MD 20902

29d. Date signed (Month. Dav. Year)

Feb. 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Physician/ 201^{Yea} ам February Thi Vo 6:40 Anh Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) Hours 579-25-3404 Director 1 🗆 M 2 🔀 F 67 April 15, 1944 Vietnam Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be n Funeral 11013 Cone Lane 20902 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ Specify: Asian Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Hotel Manager Hospitality other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H ပ္ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Mua Van Tran/Husband 11013 Cone Lane, Silver Spring, MD 20902 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State FebDate 6 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. injury or Metropolitan Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA permit. Signature of Euperal Service License P22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. Man 500 University Blvd. W. Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ a Bronchioalveolar disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Exact Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

to the Funeral Director: After this certificate it 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D67355 February 3, 2012

Registrar
DHMH 17 Rev 06-2011

State

artis

1500 Forest Glen Road, Silver Spring, MD 20910

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Daniel Sherk, MD

06 2012

31. Date filed (Month, Day,

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of Ma	arylan			nt of H e <i>of D</i>			/lental Hy	_	2011	0 0577	6
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		5. Social Security N	WRNMN umber 6. S		e (In ure Is	ast birthday)	If Unde	r 1 Year	ETHE	SDA er 24 Hrs.	8. Date of Bir	<u> </u>		OMERY irthplace (State or Foreig	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 | 2

			For State Registrar	State of Marylan	-	tificate of D			eg. No.2	12	05777
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	—·;				2. Date of Deat Month	:h	Year	3. Time of Death
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فالمسدد	Examin	er	Meritus Medical C			Hagerst			Washi		n
	Funeral		5. Social Security Number 6. Sex	9 , 3	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Count	lace (State or Foreign ry)
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	and show	힏	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				11	0d. Inside City Limits
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2XXXMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Yes, specify Cubar		rican, etc.)	Specify:	k, White, ϵ	ite
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	the Ho hin 24 the Fu mplete	Mec	only one) 3 Certifying Nurse	er: On the basis of examination Practitioner: To the best of the b	my knowledge	death occurred at the	he time, date and p	lace, and due to th	ne cause(s) and n 29d. Date signed	nanner as s	stated.
	P		29b. Signature and title of certifier MUHA MMCT	A212		29c. License			2/12	-//2	July, 1041/
	11		30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type, F	Print)	ldo892 LCamp			2	1742 on, 40
	4		Mohammed A:	202,MD1	1116	Medica	l Camp	us Rd	Huge	stor	on, we
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 300PM ai Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 15 DUW 7. Age (In yrs. last birthday) 79 yrs. ar If Under 24 Hrs. 8. Date of Birth 9. Birthpace (State or Foreign **Funeral** 228-42-3243 1 M 2 XF Min Year) 933 Jän". Virginia **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Maryland Washington County Hagerstown 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 11323 Manse Rd. 21740 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude S. Hasler Roy H. Armentrout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Wishard-son 324 Craigshop Rd. Mount Sidney, VA 24467 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 2-14-2012 Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown. MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of: signed by the attending physician and deed be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate bever thours after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death Month Day Year Yes 2X No Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown **Director:** After this certificate has been sin by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita! Other: 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1/ Natural injury 5 Pending 1 Tes 2 🗀 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) IU-15

State Registrar

State

29b. Signature and title of certifier

- X

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 3. Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 7, 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6, Physician/ Mary Lena Windsor February 2012 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5611 59th Avenue Prince George's Riverdale 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y 1 🗆 M 2 🖾 F Months Hours Min. **Director** 74 215-36-4149 June 1937 Pennsylvania Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Prince George's 1 Tes 2 X No MD Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b 5611 59th Avenue 20737 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ဂ္ Joseph Salute Evelina Darcangelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Michael W. Windsor / Son 1042 Filbert Street, Stephens City, VA 22655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 2/11/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 12 Oc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical that the death certificate be attending pl IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an Jas autopsy

68760 Box P.O. Records, page 2 certificate Hospital or Attending Physician: Division of Vital this

nours after death.

neral Director: Af

Be

မ

25. Was case referred to medical

1 Yes

27. Manner of Death

1 Natural

Accident
Suicide

Suicide
Homicide

2 X No

5 Pending

Investigation 6 Could not be

determined

completed the 0

Certificate: within 24 hours a Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover PKWY. Greenbett MD. 20170

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Hospital:

State Registrar 26. Place of Death (Check only one)

2 🗌 No

28c. Injury at work?
1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Jamary 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deat surnie Glev If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** If Under 1 Year 7. Age (In yrs. last birthday) (Month, Day, Year, Days **Director** 212-42-2183 1 □ M 2**X** F 70 Yrs. 1941 Maryland 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 182 Virginia Lane Apt 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: **Black** 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien 27 is marked other th Special Education Trainer 12th Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rena A. Johnson John H. Watkins Sr beamit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is m.
any injury or other-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curlene Dennis(Daughter) 182 Virginia Lane Apt C Glen Burnie, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Adams U.M. Church 2-4-12 Lothian, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wm Nam Reeses of actions Mortuary, P.A. 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final rteriosclero Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dae to (or as a consequence of) g physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal Co. Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ___ Por in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas autopsy performed? Yes 2 Hospital or Attending Physician: The **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending or 24 hours after death.

e Funeral Director: After tuneral Director: After tuneral pletely filled in by the fun 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Deputy 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) ONES Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Amend#17&18perfuneralhome2/80@1011CatedofiDeath 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death -Month Phrua Physician/ RICHARD ARCHIE WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death c. County of Death Plata a (pn narles If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**√** M 2 □ F Hours MARYLAND Director 218-20-0077 86 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MARYLAND CHARLES 1 X Yes 2 No LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 POTOMAC STREET 20646 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 XYes 2 No 1944—
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Specify: Specify: BLACK 3 🛛 Widowed 4 🗆 Divorced 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 4TH GRADE CARPENTER CARPENTRY Be laryland 18. Mother's Name (First, Middle, Maiden Surname) Julia Cecelia 17. Father's Name (First, Middle, Last) SYLVESTER WILLIAMS William Sylvester Williams JULIA DUNMORE WILLIAMS Dunmore Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESIA M. HICKERSON / DAUGHTER 2902 APPLE GREEN LANE, BOWIE. MARYLAND 20716 Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VEIERAN CEMEJERY FEBRUARY 17,2012 CHELTENHAM, MARYLAND permit. 21. Sov at re of Funeral a rvice Lensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN THORNTON JOHNSON MO0583 HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Aspiration disease or condition resulting in death) Pheumoni 1 week Medical Due to (or as a consequence of) Examiner OPD 7 I year Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 X Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 🗷 No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Natural Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners to the best of my knowledge, death on 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) much 069 566 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Garrett Avenue, La Plata IMD 20646

Registrar DHMH 17 Rev 7/2009

State

Ivelisse Michel , MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #1,2,7,1 - State 8, 18. 2/17/12 M.S. Kent Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201/2 Jaseph Wwesley Wilson **Physician** 02 1936 10 2;07 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Chestertown Chester River Hospital Center Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/1/1936 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 214-32-1529 76 MD Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Sm 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprinter must be notified. Worton Kent MD Director 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26579 Bigwoods Rd 21678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Local 199 Elementary/Secondary (0-12) Construction Laborer 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Wilson Edna Banks Elizabeth Banks ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26579 Bigwoods Rd Worton, MD 21678 Amy Wilson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Worton, MD NCCOL 25/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kenneth Walley Funeral Foresr Dr. Annapolis, Service 1922 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocard disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dergension Sequentially list conditions, if any colling to in modal cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi sabetes resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ vascular 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 191 autopsy performed' 2 □ No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 24 hours after death. 1 ☐ Yes 2 ☐ No Il Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) n 202.13-32 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print er/our MD 3/620 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2012 2 11:45 AM Herman Lee Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3214 Norbeck Road #213 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** M 2 🗆 F Hours Min Months LO-19-1930 **Director** 231-28-7035 81 Newport News, VA Usual Residence of Decedent show 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location irector Yes 2 No MD Montgomery Silver Spring Ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3214 Norbeck Road #213 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Dates. 1952 Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 ☐ No Specify. "natural", 3 Widowed 4x Divorced Completed African American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other to Government Systems Analyst traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Williams Myrtle Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i and 2 sho of Health ar fitem 27 it or other tre 19318 Tattershall Dr, Germantown MD 20874 Jane Williams Fuller, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Chesapeake Crematory 2/13/2012 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, 10) Inc 7400 Georgia Ave., N.W., Wash., DC 20012 Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophageal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician Physician/Medical the the hed signed by the þ

Ph. sician/ Medical Examiner

Baltimore, Maryland 21215-0036

Completed cate has I Certificate: To Be this hin 24 hours after death.

the Funeral Director: After πpleted filled in by the funeral

Medical

29a. Certifier

29b. Signature and title of certifie

/MD

07 2012

30. Name and address Jimmy Hwang,

Division of Vital Records, P.O. Box 68760

resulting in death) Last	Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? 2 \(\text{No} \) No \(3 \text{ \text{Probably}} \) Probably \(4\frac{\frac{1}{3}}{3} \text{ Unknown} \)			
		24a. Was an autopsy performed?				
25. Was case referred to medical	26. Place of Death (Chec	k only one)				
examiner? 1 Yes 2 No	ospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 \square Nursing H	ome 5 🗶 Residence	6 ☐ Other (Specify)			
27. Manner of Death 1 Natural Comparison Natural Natural Natural Natural Natural Natural Natural Natural Natural Natural Natural Natural Natural	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred .			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	t and Number or Rural Route Number,			

🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year, February 6, 2012

Washington, D.C. 20007

29c. License number

MD 33109

DHMH 17 Rev 7/2009

State

Registrar

within To the

3800 Reservoir Road, N.W.

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or											gible.		
		For State		State	ot ivia	ıryıanı		ertificat			and iv	/lental Hy			110	0 ==	105
		Registrar 1. Decedent's Name (First	t, Middle, L	ast)				rimout	0012	Outin		2. Date of De		- Same	J 	3. Time of D	eath
Physicia Medic		Eugenia	Wit	tlin								Februa:	ry 0	3, 2	2012	09:55	М
Examin		4a. Facility Name (if not in						Town, or Location of Death					y of Death				
Funeral		Hebrew Homes 5. Social Security Number		Greater Sex			ton st birthday,	If Unde	ckvil r1Year	If Unde		8. Date of Bir	th			place (State or F	oreign
Director		578 – 60–598		1 □ M 2 🗶 F		98	Yrs.	Months	Days	Hours	Min.	SEP 13,	y 191	13 Poland			
nd how at	al Director	Usual Residence of Decederation 10a. State 10b.	dent County		Т	10c. City, Town or Location										10d. Inside City	Limits
Maryla '8a-f s tified		MD M	ontgo	mery		Kensington										1 🗌 Yes 2	X No
h the tage or 2 be no		10e. Street and Number							p Code			10g. Citizen of What Cour United Stat					
ms 23 must	Funeral	3618 Littl	edale		adopt Ev	or in LIS	12		0895	enanic Or	rigin? (Spe	acify Yes or No-				can Indian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 3 🛣 Widowed 4 ☐ [Armed Fo	orces2 2 A ve	es2 2 A No 1 Yes				Decedent of Hispanic Origin? (Specify Yes or Nos, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:					ck, White		
"natul	plete			s Education grade completed	1)		16a. Dec	edent's Usu e <i>kind</i> of wo	al Occupa	ation Jurina mos	st of work	ing	16b. k	Kind of E	Business II	ndustry	
ygiene. her than t, the Me	e Completed	Elementary/Seconday						po not us gner						heat		<u> </u>	
oe filed ntal H ed otl	To B	17. Father's Name (First, I	<i>Viiddl</i> e, Las	st)	G	alew	cka			18. Moth		e (First, Middle,	<i>Maid</i> en		_{re)} (ryos	ka	
ould burd Me		19a. Informant's Name/R	elationship	(Type, Print)		arew	1	lina Addres	s (Street a			al Route Numbe	er, City o				
id 2 sh ealth a n 27 is ertrau		Harriet Tr	itell	/ Guardi	Lan							Bethesd					
Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cre 4 ☐ Donation 5 ☐	emation 3		n State	C	emetery, cr	oosition (Na ematory or Cren	other plac			Date 5/2012			- City or ī u rni e	Town, State	
permit. Departr Imports any inju		21. Signature of Funeral	Service Lic	My		MO	0956	Thib 7 Pa	nd Addres adeai rk As	s of Facil	tuar Ga	y Servi ithersh	ice,	p.a	208	77	
		23a. Part 1. Enter the dis				the death	n. Do not er				_			,		Approximate Interval Betwe	en
Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ire. List offi	_ a D	e m	consequ	ence of):									Onset and De	
	iner	Sequentially list conditio if any, leading to immedi- cause. Enter Underlying	ns, ate	b. Due to	(or as a	consequ	ence of):										
executed an and rial-transi	l Examiner													_			
ate be hysicia the bur	dica	d										-	.				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	of pregnancy 2 Fetal death 3 Ectopic pregnancy t time of death 5 Other (specify)						23d. Date o				very Day Ye	ar			
at the ed by t detach		Part II. Other significant	condition	s contributing to	death bu	ıt not res	ulting in the	underlying	cause giv	en in Par	t I.	23e. Did 1	tobacco	use con	ntribute to	the cause of dea	ıth?
uires the signer of the signer	d by											1 🗆	Yes 2	No 🔀	3 🗆 Pr	obably 4 🗆 Ur	nknown
law requ has beer e 2 shou	Completed											24a. Was		24b.	. Were aut prior to o death?	opsy findings ava	ailable use of
n: The ficate nr, pag		25. Was case referred to	medical						26 DI	aco of Do	oth (Choo		2 X N	No		2 🗌 No	
ysicial s certi directo	To Be	examiner?	medical	Hospital:	Inpatie	nt 2 🗆	ER/Outpat	ient 3 🗆 🛭	Othe	er.		ome 5 \square Resi	idence	6 🗌 Otl	her (Speci	fy)	
nding Phy tth. : After thi e funeral o		27. Manner of Death 1 Natural 5 Death 2 Accident	Pending	28a. Date (Mor		у	28b. Time injury	of	28c. Injury work	/ at		28d. Describe				,	
tal or Atter s after des al Director ed in by th	Il Certificate:		Could no determin	ot be 28e. Place	e of Inju ling, etc	ry - At ho . <i>(Sp</i> ec <i>ify</i>	me, farm, s	street, facto	ry, office			28f. Location (City or To			ber or Rur	al Route Number	r,
e Hospit 124 hour e Funera bleted fill	Medical	(Check 2 D N	ledical Ex	Physician: To the aminer: On the ba lurse Practioner	asis of ex	amination	and/or inv	estigation, in	my opinio	on, death	occurred a	t the time, date	and plac	e, and d	ue to the c	ause(s) and manr	ner stated.
within To the	-	29b. Signature and title o		li				29	c. License	number			29d. Da	ate sign		, Day, Year)	
		30. Name and address of Mina Fo	person wh			eath (Item	23a) (Type M c	Print)	٩	Rd	R	ockvill	R 1	MD	20	823	
Stat Registra		31. Date filed (Month, Day	y, Year)			r's Signa	ture	itros				-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 29d per doc 9925 3-2-12 yt.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		,	Certif	icate of L	Death		Reg. No. 2	012	057	85	
	Physicia	n/	1. Decedent's Name (First, Middle, La	est) Eric Hill	Waune				2. Date of De	oth Day 5,	2012	3. Time of De 2025	eath M	
	Medic Examin		4a. Facility Name (if not institution, giv		wagne	41		Location of Death	1		inty of Death			
-				ss Hospita	(In yrs. last bi	rthday) I	Silv FUnder 1 Year	er Spriv		th		gomery blace (State or F	- Foreian	
	Funeral Director			1 ★ M 2 □ F	64		onths Days	Hours Min.	(Month, Da	(Month, Day, Year) Narch 31, 1947 Michigan				
	show at	jo	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Locati	on		Modecit	<u> </u>		0d. Inside City	Limits	
	Maryla 28a-f s otified	I -≔ I		jomery				Silver Sp	oring			1 🗆 Yes 2	No X	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number	.orain Aven		10f. Zip Code	20901		10g. Citizen of What Country?					
36	ifter death ", or item aminer n	þ	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 🔊 Yes 2 🗆 I	No	1	Decedent of H s, specify Cuba Yes 2 X No	ispanic Origin? (S _i .n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. F Spec	Race - America Black, White, e	etc.		
00-	natural	Completed	3 Widowed 4 Divorced 15. Decedent's			a. Decedent	's Usual Occup	ation			of Business/Inc	White dustry		
1215	hin 72 h ne. Ihan "r ie Med i	ошо	(Specify only highest g	grade completed) College (1-4 or 5- 5+	+)	(Give kind life, DO N	OT use retired)	luring most of wor	king	Libr	anu ak	ary of Congress		
d 2.	iled within 72 Il Hygiene. other than '	Be	17. Father's Name (First, Middle, Last		5+				me (First, Middle,	Maiden Surn	ame)		2.5	
ylan	uld be f Menta narked natic ev	욘		dward Hill							ne Holi			
Mar	12 should alth and Me 27 is mar		19a. Informant's Name/Relationship Margaret N. Way			b. Mailing <i>F</i> 10008	Lorain	Ave., S	iral Route Numbe ilver Sp	er, City or Tow. Ving,	n, State, Zip C M <mark>aryla</mark>	nd 2090)1	
Baltimore, Maryland 21215-0036	age 1 and ant of Hea it: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemet	ery, cremate	on (Name of ory or other place On Chem		Date 5/2012		on - City or To		nd .	
Baltir	permit. Page 1 an Department of He Important: If iten any injury or oth		21. Signature of Funeral Service Lice		1237	22. N	ame and Addre							
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused	the death. Do	not enter th	ne mode of dyir	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Betwe		
-	h_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Septi	c Shoc	k						Onset and De	ath	
Sec.	Examiner			Due to (or as a		e of):								
	D 70	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).										
	tificate be executed ng physician and as the burial residuals.									· · · · · · · · · · · · · · · · · · ·				
8760	ate be o	Medical	d											
Ø	ndi use		IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		ctopic pregnan	су		23d.	. Date of delive	ery Day Ye	ear	
Box '	he deat y the at sched f	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 🗆 Ç	ther (specify) _							
s, P.O.	requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the und	erlying cause gl	ven in Part I.				ne cause of dea bably 4 X Ur		
of Vital Records,	The law requires ate has been sign page 2 should b	Completed							24a. Was	psy	prior to coi	psy findings ava		
Rec	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical				20 B	1.D. H. (0)		ormed? 2 X No	death?	2 No		
Vita	ysiciar is certif directo	To Be	examiner? 1 Yes 2 X No	Hospital:	ent 2 ER/0	Outpatient		er: 4 Nursing 1	Home 5 Resi	idence 6 🗆	Other (Specify)		
Jo L	ling Ph ≀r After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of injui (Month, Day	ry 28b	. Time of injury	28c. Injur wor		28d. Describe	how injury oc	curred			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 280 Place of Init	ury - At home, c. (Specify)	farm, street		res Z 🗆 NO	28f. Location (City or To		ımber or Rural	Route Number	ır,	
Ö	spital c		29a. Certifier 1 X Certifying Pi	hysician: To the best of	mv knowledge	e, death occ	urred at the tim	e, date and place,	and due to the d	cause(s) and n	nanner as stat	ed.		
	the Ho nin 24 h the Fur npletely	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	miner: On the basis of eaurse Practitioner: To the	xamination and e best of my kr	l/or investiga owledge, de	eath occurred at	the time, date and	at the time, date place, and due to	the cause(s) a	ind manner as s	stated.	ner stated.	
	24+1		29b. Signatur and title of certifier	rmy Ve	l la	ppan	29c. Licens	e number D00672	79	February January	gned (Month, I a ry 244-06,	2012		
			30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type, Prin	t)						0010	
	Sta	te.	Suganthi Alagar 31. Date filed (Month, Day, Year)	32 Registra	opan, M ar's Signature			rest Gle	n Koad,	Silve	i Sprin	ig, MV 2	0410	
	Registr		FFR 0.8 2	112 /2	1.	BAU	W.							

			For State Registrar	State of Mary		artment of H			ene 3. No. 2012	05787
	Physicia	nn /	Decedent's Name (First, Middle, Language)	ast)				2. Date of Death		3. Time of Death
E	Medi	cal		lliams				Februar	y 1,2012	
	Examin	ner	4a. Facility Name (if not institution, giv		U227	4b. City, Town, or l	ocation of Death	t c	4c. County of Death	Georges
	Funeral			Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g. Birt	hplace (State or Foreign
	Director		263-32-5121 Usual Residence of Decedent	1 □ M 2 🔀 F	87 Yrs.	Months Days	Hours Min.	March 2	2,1924 ^{Col}	GA
	yland f sho	ţō	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	r 28a- notifii	Director	MD P	G	Capito	l Height	s			1 LxYes 2 □ No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	iral	1207 Addison	Dood Couth	# 227	10f. Zip Code 2074	2	10	g. Citizen of What Co United S	,
	leath vitems	Funeral	11. Marital Status	12. Was Decedent Ever i		Vas Decedent of His f Yes, specify Cuban		cify Yes or No-	14. Race - Amer	ican Indian,
36	after c	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		Yes 2 No		(Idan, etc.)	Black, White Specify:	, etc.
5-0036	atura cal E	Completed	3	Year or Dates.		lent's Usual Occupat		14		ack
215	in 72 h e. han "n	Jam's	(Specify only highest of Elementary/Seconday (0-12)	grade completed) College (1-4 or 5+)	(Give	kind of work done du O NOT use retired)		ng is	ob. Kind of Business i	ndustry
2121	d with lyglen ther th	BeC	12	,	Но	ousekeep	er		Private	
Maryland	should be filed within 72 hours after and Mental Hyglene. is marked other than "natural", raumatic event, the Medical Exan	10 B	17. Father's Name <i>(First, Middle, Last)</i> Joshua Hill)			18. Mother's Name Olivia	(First, Middle, Ma Johns	,	
ary	nd Me s mari		Joshua Hill 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street ar	ad Number or Pumi	Pouto Number C	ity or Tayun State 7in	Code)
	and 2 st Health a tem 27 is		Carol Banks/d	aughter	1041 BOW	1 Elder Le MD.	2072110	w Drive	!	5559
Baltimore,	= 0		20a. Method of Disposition 1 XBurial 2 Cremation 3	☐ Removal from State	Ob. Place of Dispo	sition (Name of	i D	ate 20	oc. Location - City or	Town, State
tim	permit. Page 'Department o Important: If any injury or once.		4 Donation 5 Other (Spec	cify) Z	Arlingto	on Nat.	Cemeter	y A	rlington	,VA
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice	PAILE IN	1 1 39	.Name and Address 910 Silv	of Facility HO er Hill	ages & Rd., S	Edwards uitland,	MD.20746
	3		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the						Approximate
	Physician/		Immediate Cause (Final disease or condition		STIVE	HEAR	T FAIL	WRE		Interval Between Sinset and Death
-	Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	HEAR VE HEA				DECADEC
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. HUPE Due to (or as a cor	ATENSI nsequence of):	VE HEA	ant v	ISEASE		VICADES
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	securiones of:					
0	be exessician burial	dical E	lesditing in deathy East	Due to (or as a cor	isequence oi).					
68760	ficate g physas the	Nedi		d	•					
39 ×	eath certifice attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Date of deli	•
Вох	t the deat by the at tached fo	ysici	1 Yes 2 No	4 ☐ Pregnant at time g ☐ Unknown	e of death 5	Other (specify)			Month	Day Year
P.O.	hat the	by Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S, I	uires t n sign uld be	q pa	DIABETES	MELLITUS,	SENIL	E DEMENT	TIA	1 🗆 Yes	2 No 3 □ Pr	obably 4 🗆 Unknown
Records,	law require has been si e 2 should	Completed						24a. Was an autopsy		opsy findings available completion of cause of
Rec	The la	Com						performe	ed? death?	2 No
of Vital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Plac	ce of Death (Check	only one)		
of V	Phys er this eral dii	e: To	1 Yes 2 No 27. Manner of Death	28a. Date of injury	2 ER/Outpatier 28b. Time of	t 3 DOA Other	4 U Nursing Hor	ne 5 Residence 8d. Describe how	be 6 Other (Speci	fy)
ou	anding ath. Ir: Afte	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		ar) injury	work?	es 2 □ No	04. 2001.20 1.01	mijary dodanod	
Division	Hospital or Attending Physician: The law requires that the death certificate be executed \$4.4 hours after death. Luneral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 Suicide 6 Could not 4 Homicide determined			eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical Exar	ysician: To the best of my k niner: On the basis of examinates Practioner: To the best	nation and/or invest	igation, in my opinion	, death occurred at t	the time, date and p	place, and due to the c	ause(s) and manner stated.
	To the vithing to the complete	_	29b. Signature and title of certifier			29c. License r	number	290	d. Date signed (Month	. Dav. Year)
	PA.		30. Name and address of berson who Peter M SC	completed cause of death	(Item 23a) (Type, P	rint)	Ct D	or Cora	enbolt. N	10 20770
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature		-j : '	, -16	CH. C.	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Walter 10,2013 11:30PM Virginia K. Medical rebruary 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Zens Nursing Nre De 8. Date of Birth Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 □ M 2 🎖 F Hours Min. Country) Manth, 28 Year) 918 **Director** 217-18-2503 Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director Maryland Harford Havre de Grace 1 🗌 Yes 2 🎗 No 10e. Street and Number 10f. Zip Code r items 23a or iner must be n ò 10g. Citizen of What Country? Funeral UnitedStatesofAmerida 21078 140 Darlington Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Family <u>Homemake</u>r Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lucy Roscoe Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Darlington Rd., Havre de Grace, MD 21078 Richard Walter (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date West Chester, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02/13/2012 RA Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Immediate Cause (Final disease or condition Onset and Death Physician UNY Medical resulting in death) Due to (or as a consequ Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physicis yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a Was an performed? filled in by the funeral director, 25. Was case referred to examiner? 26. Place of Death Check only one) Be Hospital: Other: 1 🗌 Yes 2 **W**No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date sidned (Month, Day, Year, 1 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MU

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Courtney Gene Whetzel Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Western Maryland Health System Cumberland If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Director 1**XX**M 2 □ F 234-48-2913 79 06/22/1932 Moorefield, WV Ital Hygiene. or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No WV Hampshire Green Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral HC 86 Box 57 26722 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Race - American Indian, 11. Marital Status Armed Forces? 1X Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Machine Tender Paper Mill Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ၉ Guy Amby Whetzel Ola Naomi Mongold other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Shirley Whetzel (wife) HC 86 Box 57, Green Spring, WV 26722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9 Department or Important: If any injury or once. WVU Memorial Vault 02/14/2012 Morgantown, WV 4 ■ Donation 5 □ Other (Specify) 22. Name and Address of Facility WVU Human Gift Registry Signature of Funeral Service Licenses PO Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of) h sician/ disease or condition resulting in death) Medical **Examiner** Due to the as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury tranand that initiated events Due to (or as a consequence of) resulting in death) Last burialby the attending physician stached for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has builtector, page 2 s autopsy performed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 Yes 2 🖼 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD 13/12 072514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Cumberland 12200 31. Date filed (Month, Day, Year) State FEB 2 7 Registrar

Registrar DHMH 17 Rev 7/2009

State

5) RM

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Tidewoler

30. Name and address of person

31. Date filed (Month, Day, Year) FEB 14

Box 68760

P.O.

Records,

of Vital

Division

who completed cause of death (Item 23a) (Type, Print)

Colony

0070900

Dr. Suite IA, Annopolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No Certificate of Death 1. Decedent's Name (First Middle, Last) 2 Date of Death February Day, 2012 ar Physician/ \mathbf{P}_{M} 8:35 **JAMES** YUN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Casey House- Montgomery Hospice Rockville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month. Dav. Year 446-46-3983 76 Director 1 **X** M 2 □ F Jan. 30,1936 Korea Usual Residence of Deced 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland | Bethesda 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 6007 Folkstone Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify "natural", Completed 3 Widowed 4 Divorced Asian Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working l Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Accounting the Certified Public Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Kumsan (Frances) Choi Jae Chun (Paul) Yun · traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 6007 Folkstone Road, Bethesda, MD 20817 Sue Yun (Spouse) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cof) Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Silver Spring, MD Gate of Heaven Cem. 2012 21. Signature of Funeral 22. Name and Address of Facility DeVol Funeral Home Thu (M01117)10 East Deer Park Dr. Gaithersburg, MD 20877 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician are the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed within 24 hours after death.
To the Funeral Director: After this certification by the completely filled in by the form 2 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Hospice 1 ☐ Yes 2 → No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Registrar

DHMH 17 Rev 06-2011

State

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day,

Dr. Bindu Joseph M.D.

07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) February 3. 2012

29c. License number

D0060634

6001 Muncaster Mill Road, Derwood, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2

		•	For State Registrar		State of Ma	ai yiai iu 7	•	ificate of L			Reg. N	0010	10.5	792
	Physicia	n/	1. Decedent's Name (F							2. Date of De Month		2012 Year		of Death
	Medic Examin		Hugh 4a. Facility Name (if no		Wayne street and number)	Y.C	ung	4b. City, Town, o	r Location of Death	Feb		County of Death	212	U "
~.1		Н	Allegany 5. Social Security Num	y Health I	Nurs. & Re	hab. C	tr.	Cumb	erland If Under 24 Hrs.	8. Date of Bir		Allegany		as Familia
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	land show dat	tor	10a. State 10	0b. County		10c. City, Tox							10d. Inside	City Limits
	e Mary r 28a-f notifie	Jirec	MD 10e. Street and Number	Allega	any		LaV							es 2 🗆 No
	n with th	Funeral Director	112 Lon					10f. Zip Code	21502			itizen of What Cou USA		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married	2 X Married	12. Was Decedent E Armed Forces? 1 XYes 2 ☐ I If Yes, Give	No		as Decedent of H Yes, specify Cuba □ Yes 2 XNo	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ameri Black, White, Specify:	etc.	
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ylan	should be filed n and Mental Hy is marked oth raumatic event	잍	Arthu	r Wayne	Young				Mary	Catherine	Atkir	ns		
Mar	d 2 shou alth and n 27 is m er traum		19a. Informant's Name Wilda "Te	e/Relationship (<i>Typ</i> erry" Young			-	Address (Street 2 Long D	and Number or Ru Prive		r, City o Vale		Code) MD 2	1502
Baltimore, Maryland 21215-0036	Page 1 and ment of Heal ant: If item 2 ury or other				Removal from State	cemet	tery, crema	ition (Name of atory or other place lemorial G		Date 2/18/2012		ocation - City or 1	own, State	MD
Baltir	permit. Page Department o Important: If any injury or once.		21. Sanature of Juner	- 11		T TCOL		Name and Addre	ss of Facility Delli Funeral I	Home, PA				IVID
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.											Approxim	ate		
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_	ificate be executed g physician and as the burial-transi		that initiated events resulting in death) Las	it L	Due to (or as a	consequence	e of):							
8760	ificate ig phys as the	Medical	IE EENAA! E:		d			· · · · · · · · · · · · · · · · · · ·			_			
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/I	IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?	23c. If yes, outcome of 1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal dea		Ectopic pregnand Other (specify) _	су			23d. Date of delin Month	very Day	Year
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Vita	nysicia iis certi directo	To Be	examiner?	/ la	lospital: 1 🗌 Inpatie	ent 2 🗆 ER/0	Outpatient	Oth	or /		dence	6 ☐ Other (Specif	5y)	
on of	nding Pt ath. r: After th ie funeral	Certificate:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending Investigation	28a. Date of injur (Month, Day)	y 28b.	. Time of injury	28c. Injur work M 1 🗆		28d. Describe h	now inju	ry occurred		
Division of Vital Records,	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc		farm, stree	et, factory, office		28f. Location (S City or Tox		nd Number or Rura e)	al Route Nur	nber,
	e Hospit 24 hour e Funera sleted fille	Medical		Medical Examin	ician: To the best of reer: On the basis of exercitioner: To the basis of the basis	amination and	Vor investig	gation, in my opinie	on, death occurred	at the time, date a	and place	e, and due to the ca	ause(s) and r	nanner stated.
	To th Withii To th	-	29b. Signature and title		0 -	<u> </u>	3., 30	29c. Licens		/		ate signed (Month,		
			30. Name and address	of person who co		eath (Item 23a)	(Type Pri	int)	-1486	>		213.16	2(50	212
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 5 a M an Medical Mary S. Zimmerman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number '. Age (In vrs. last birthday) **Funeral** Country)
est Virginia Days Months Hours Min. (Month, Day, Ye. 2/3/1922 1 □ M 2 🕱 F 89 West Director 579-20-0225 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Examiner must be notified at Director 1xxYes 2 No or 28a-f White Plains MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with til Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral USA 20695 4778 Desert Rose Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2**X** No Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify 3 X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Program Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Sybilla Fink Leslie J. Stickles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4778 Desert Rose Ct. White Plains, MD 20695 Carol Powers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2/6/2012 Cheltenham, MD 4 Donation 5 Other (Specify) Maryland Veterans Cem Signature of Fundal Service Licens 22. Name and Address of Facility Huntt Funeral Home 900 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Oin Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a l for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached for 9 🔲 Unknown 9 Unknown P.0. Other significant conditions contributing for death but not resulting in the underlying cause given in Part I. tribute to the cause of death? 23e Did tobacco use di <u>\$</u> 1 Tyes No 3 Probably 4 Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of cate has I autopsy death? perform 24 hours after death.

Funeral Director. After this certificate leted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 ပ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated or integrated best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie сотретер (Check within 2 only one 29d. Date sign 29b. Signature 30. Name and address of person who completed ON

Registrar

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,19a per fh g924 2-24-12 vt
State of Maryland / Department of Health and Mental Hygiene State RegistAMEND#23a(a) per CRNP, 2/1/12/BMW, McCCertificate of Death Reg. No. 2. Date of Death

John . 28 p2/012 Year 1. Decedent's Name (First, Middle, Last) 3 Time of Death Zolotovitskaya Physician/ Tamara 0950 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1072877926 Russia Director 85 none 1 🗆 M 2 🔀 F Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director Germantown 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20874 Azerbaijan 13925 Rockingham Road items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner and once. Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after (Health and Mental Hvgiene. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify 3 X Widowed 4 □ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Geologist Science Be 17. Father's Name (First, Middle, Last) Arkadiy Zolotovitskiy 18. Mother's Name (First, Middle, Maiden Surname, 2 Arnadiy Polina Zolotovitskaya Zolotovitsky 19a. Informant's Name/Relationship (Type, Print)
Spartak
Spartan Agamir/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13925 Rockingham Road Germantown, Md 20874 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State Trinity Cem, 1/30/2012 Elkridge, Md. Holy 4 Donation 5 DOther (Specify) Signature PHILIP D'RINALDI EUNERAL SERVICE, P. A. 9241 Columbia Biva. Silver Spring, Ma20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each merebrovascular Accident Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} Intercranial hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Secute thally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 as the b attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 X No the a detached 9 Unknown 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 X Other (Specifynospice within 24 hours after death.

To the Funeral Director. After thi 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201

State Registrar 6001 Muncaster Mill Rd Rockville, Md 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2- Registrar's Signature

Deborah Miller

JAN 3 0 2012

31. Date filed (Month, Day, Year)

AMEND PI LINE B, 25,27,28A-F, PER ME G928 6/28/12 TRT Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day, 2012 February 5:20 A Barbara Ann Zanelotti Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min. 05/26/1940 Washington, DC Director 71 577-56-6341 Usual Residence of Decedent show 10a. State item 27 is marked other than 'natural', or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 HNo Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 420 West Dares Beach Road, Apt. 207 United States 20678 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Maud Prestele Jerome Louis Zanelotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12855 Lake View Drive, Lusby, Maryland 20657 Margaret Z. Hoofnagle / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or o cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/09/2012 Metropolitan Crematory Alexandria, Virginia permit. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SPINAL FRACTURES WITH COMPLICATIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parablegio Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe ours after death.

eral Director, After this certificate tifled in by the funeral director, page 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes Z No Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending DEC. 2011 **UNKNOWN** M 1 ☐ Yes 2X No PROBABLE MULTIPLE FALLS Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 420 W. DARES BEACH RD, 207 PRINCE FREDERICK, MD 4 Homicide determined HOME Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C 6a6-4 M.D. D54346 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA B-SATTA M.D., 24035 THREE NOTCH ROAD SRW MD 206 HELLY WOO 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 28c per me, 9925,03/08/2012dhb
State of Maryland Department of Health and Mental Hygiene

1- State Amend Item 26 per verb., g924,02/28/2012dhb
Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month Year 10:55 PM Kirsten Michelle Anderson 02 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 🖺 F Months Hours Min Director Vrs 220-02-0473 29 MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 78 Mellor Ave. 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗵 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Recruiter Wood Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Douglas William Anderson Laura Ellen Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Anderson/Sister 103 South Rolling Road, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 2/24/2012 Winfield, MD 22 Name and Address of Facility Funeral Home & Crematory, P.A. Burrier-Queen Funeral Home & Crematory, P.A. Winfield, MD 21784 21. Signature of Funeral Service Lice AM Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ hy 10x.C 15 chemic encephal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 48 hours obstructio airuau Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine Due to (or as a conseque ce of). 42 hours Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed tood りゅしいら and -trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 1 No 1 Tyes Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ Other: 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending 23:07 PM Choked 2. Accident 02/19/12 1 Yes 2 **X** No on tooch Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Num City or Town, State) 1917 Streaker Sykpoville MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined home dt Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 21 02 2012 D0062843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12441 Parklann Dr. 0 Rockville MD 20852 Crompton 31. Date filed (M Year 8 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 2012 ae IVES 8:67 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE HERITAGE CENTER DUNDALK 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Under 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Min. (Month, Day, Year) 10-22-1924 Director 219-22-6246 A 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1x Yes 2 ☐ No MD BALTIMORE TURNER STATION ъ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 317 PINE STREET 21222 USA items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. or i Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: Year or Dates BLACK the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE COUNTY LIBRARIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GARNETT H. PARSONS. SR. SUSAN BRACEY 19a. Informant's Name/Relationship (Type, Print) NIECE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA PARSONS BILLINGS 4601 BRIGHTWATER COURT APT. M OWINGS MILLS, MD 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date any injury or 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 3-3-2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final IABETES Physician/ MELLITUS disease or condition resulting in death) Medical ERTENSION Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed EMEN MA that initiated events resulting in death) Last VASCULAR DISEASE RIPHERAL physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion death? 1 Yes 2 No autopsy Yes 2 1 Division of Vital 25. Was case referred to medical Be 26. Place of Deat (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, completed filled by the funeral 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Investigation 6 Could not be Accident hin 24 hours a er deat the Funeral Director 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

only one 29b. Signatu

the

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Mariel-Place Dundalle MO2122

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D21, 2012 Physician/ Elvire Eugenie Marie Ahouanmenou February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours 219-51-1353 **Director** 1 🗆 M 2 🗓 F 57 December 21, 1954 Benin Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Montgomery 1 🗌 Yes 2 🏝 No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8218 Tuckerman Lane 20854 France / Benin items "natural", or item ledical Examiner n Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Specify: Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gabriel Gounongbe Agnes Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desire Ahouanmenou /Husband 8218 Tuckerman Lane, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland 21. Signature of Fun ral Service Licensee Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Myelette Barnist M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-2805 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 7 days Perianal Abscess Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or injury that initiated events End Stage Liver Disease l Year burial-tran the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 1 Year Metastatic Liver Disease IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No page 2 should be detached for Year Day 1 ☐ Yes ∠ • 9 ☐ Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Colon Carcinoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 1 🔛 Natural 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prantition of To the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 2 D71517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Natalia Maria Vasquez, M.D. 31. Date filed (Month, Day, Year, 22. Registrar's Signature Registrar DHMH 17 Rev 06-2011

B

ORIGINAL

		For	State o	of Marylan		artment of H		and M	ental Hy	giene			
		1 - State Registrar			Cer	tificate of L	Death			Reg. No	201	2	05/99
Physicia	an/	1. Decedent's Name (First, Middle, I Euro Felician	,						2. Date of De Month February		y 2012 ^{Ye}	ar	3. Time of Death 3:02 A M
Medic Examir		4a. Facility Name (if not institution, g		nber)		4b. City, Town, or	Location		rebluary		. County of E		3:02 A W
) LXdiiii		17508 Applewood		,		Rockvi		o. Doda		40	Montg		:у
Funeral	г	5. Social Security Number 6	i. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, Da			-	ace (State or Foreign
Director		214-51-1586 Usual Residence of Decedent	1 🛛 M 2 □ F	77	Yrs.	IVIOITITIS Dayo	110013		Feb. 2		35]	3raz	
and Show	5	10a. State 10b. County		10c. City	y, Town or Lo	cation						10	d. Inside City Limits
Maryla 28a-f	Director	Maryland Montgo	mery	R	ockvil:	le							1 ☐ Yes 2 🌠 No
a or 2	<u>=</u>	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Zip Code				10g. Cit	tizen of What	t Countr	y?
th with ms 23 must	Funeral	17508 Applewood				20855					Brazi	1	
or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	Armed Fo	edent Ever in U.S rces?		Vas Decedent of H f Yes, specify Cuba	ispanic Or n, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- ican, etc.)		14. Race - A Black, W		
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ary hould and M s mar		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Numb	er or Rural	Route Numbe	er, City or	Town, State	, Zip Co	nde)
y, Mal		Carmen Ribeiro	Alves/Wi	.fe	1	8 Applew							
Orether or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from	State 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Da	ate unk	20c. L	ocation - City	or Tow	n, State
DaltIMOTE, Dermit. Page 1 and Department of Hea mportant: If item any injury or othe		4 Donation 5 Other (Spe	ecify)	Cem	iterio S ier Sao	natory or other place Sao Francis Christovao	со						o, Brazil
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	holm	м0117	3 R 3	Name and Address obert A. P 00 W. Mont	s of Eacili umphre gomen	ey Fune y Aven	eral Hom ue, Rock	ne, Ro	ockville Mary	e, In land	nc. 20850
		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that of	caused the death								-	Approximate Interval Between
- Physician/		Immediate Cause (Final disease or condition	_ a Atr	ial Fib	rillat	ion							Onset and Death years
Medical Examiner	ı	resulting in death)		or as a consequ	,							1,0	
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uted d ansit	amir	Cause, Enter Underlying Cause (Disease or injury	2	betes) years
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death. Within 24 bours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ledica		d. Hyp	ertensi	on							20) years
certificant certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna Birth 2 Feta		Ectopic pregnanc				ļ	23d. Date of	deliven	y
death death che atter	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of c		Other (specify)	у				Month	D	Day Year
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al Direction			buildir	ng, etc. (Specify)				City or Tou	vn, State,			
Hospi 24 hou Funer etely fil	edical	(Check 2 \(\sum \) Medical Exa	aminer: On the bas	sis of examination	and/or invest	occurred at the time igation, in my opinio	on, death o	occurred at t	he time, date a	and place	, and due to t	he caus	e(s) and manner stated
To the within To the comple	Σ	only one) 3 L Certifying N 29b. Signature and title of certifier	urse Practitioner	: 10 the best of h	ny knowledge,	death occurred at t		ate and plac			(s) and mann te signed (Me		·
		1 Cobut	18	en	Ms	MD	22846)					, 2012
		30. Name and address of person wh				rint) Grove Ro	ad #3	306 [Pooless 4 1	1_0	Marv1	and	20850
Sta		31. Date filed (Month, Day, Year)	20.0	egistrar's Signat			au TS	, r		те,	riaryl	anu	20030
Registr	ar	FEB 2 8 21	JIZ K	wer to	1. 19 a	· · ·							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death Month Physician/ Medical lity Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randalsto 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 214-38-5873 1 Ϊ M 2 🗆 F Director 08/04/1941 DC 70 or 28a-f show 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21208 USA 3112 OLD POST DRIVE within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 5+ PHARMACIST RITE AID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) COHEN ANTWARG IDA HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE ANTWARG/WIFE 3112 OLD POST DRIVE, BALTIMORE, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State any injury or SHAAREI TFILOH CEM. 02/24/2012 BALTIMORE, MD 4 Donation 5 Other (Specify atture of Funeral Ser SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LANdio disease or condition resulting in death) Medical Due to (or as a con equence of): Examiner quentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (of as a consequence of): minhous as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day for Month Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes 2 No this certificate Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred I Director: After the din by the funeral Certificate: injury 5 Pending 1 Natural hours after death. 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number use of death (Item 23a) (Type, Print) 30. Name and address of person who completed 0

DHMH 17 Rev 06-2011

State Registrar 31 Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2 Date of Death Physician/ Month FEBRUARY 23 2012 12:45P M IRWIN ALBERT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death KESWICK MUTICARE CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Min Hours Director 080-18-1704 1 🗓 M 2 🗆 F 87 01/27/1925 NY Usual Residence of Decedent 28a-f show aţ 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits Director notified 1 Yes 2 X No MD BALTIMORE BALTIMORE 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2516 FARRINGDON ROAD 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER AEROSPACE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be file nt of Health and Mental F: If item 27 is marked ol ပ္ ALEXANDER ALBERT BELLE WEISSBERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH ALBERT / WIFE 2516 FARRINGDON ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or or 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CONG. 02/24/2012 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 22. Name and Address of Facility 21. Signature of Funeral Se SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due | (or as a conseque ce of) Examiner MAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami ronic To the Hospital or Attending Physician: The law requires that the death certificate be executed monow that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ŏ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Mellite 1 🗹 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? thrombosc 24a. Was an has autopsy perform certificate 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 8 B 26. Place of Death (Check only one) Hospital: Other: 2 🗹 No 1 Tyes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No · death. eral Director: Ai filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medican Examiner: On the basie of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npletely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

State

Registrar

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SUITE 301 BALTIMORE MD 2/20

MD

completed cause of death (Item 23a) (Type, Print)

N. EUTAW

30. Name and address of person who

JAY 31. Date filed (Month, Day, Year)

SHARMA

FEB 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	of Marylar	id / Depa	artment d tificate d	of Healt	th and N	Mental Hy		012	058	302
			Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death								Reg. No.		3. Time of I	Death	
	Physicia Medio		Joseph Ev	vert Bar	cell						Month Feb.	25, Day)12 Year	1503	М
	Examin		4a. Facility Name (if n	ot institution, give	street and num	nber)		4b. City, Tov		ion of Death		4c. Co	ounty of Death		
			Casey Hou 5. Social Security Nur					Rocky		1 0111			ntgomer		
	Funeral Director		331-42-06		ex ≰□M2□F	7. Age (In yrs. I		If Under 1 \ Months D	ays Hou	rs Min.	8. Date of B (Month, D	ay, Year)	Coun		J
W.			Usual Residence of	Decedent			Yrs.				Sept.1	6,1946	New	Jersey	7
	yland -f shc ed at	ctor	MD 10a. State	10b. County	2001		y, Town or Loc						1	0d. Inside City	
	r 28a notifi	Director	10e. Street and Numb	Montgom	= T. À	51	lver S	10f. Zip Co	do			40 000	41111	1 🗆 Yes	2/L No
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36	after d		1 Never Marrie		Armed Fo 1 X Yes If Yes Giv	rces? 2 No ates.1966—	70 "	Yes, specify			Rican, etc.)	0.0	Black, White, ecify White		
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Maryland	uld be d Mer marke natic	_	Joseph Eve				_			lga Ra		_			
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imo	Page ment c ant: If ury or			Cremation 3 🗆 5 🗆 Other (Specif		Otate	emetery, crem al Jou	-		prv 2/	28/12	Woodl	bine, M	D	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of une	eral Service Ligens	ee		22	Name and A	Idroce of Ea	oiliby					1020
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Division of Vital Records,	w rec as bee 2 sho	Completed									24a. Was		4b. Were autop	osy findings av	railable
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ta	ysician: is certific director,	Be	25. Was case referred examiner?		lospital:			2		Death (Check					
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o u	Attending Ph er death. ector: After thi by the funeral	Certificate:		5 Pending Investigation	(Mont	h, Day, Year)	injury		njury at vork? Yes 2	_	28d. Describe	now injury oc	currea		
ISIC	Attender deathecter / ector: / by the	rtifi		6 Could not be determined	28e. Place	of Injury - At ho	me, farm, stre			-			umber or Rural	Route Number	ľ,
	pital or ours afte eral Din filled in				Dullair	ng, etc. (Specify					City or To	wn, State)			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check 2	Certifying Phys Medical Exami	ner: On the bas	is of examination	and/or investi	gation, in my o	pinion, deatl	h occurred at	the time, date	and place, and	d due to the cau	ise(s) and manr	ner stated.
	To the Hos within 24 ho To the Func completely	Ž	only one) 3 29b. Signature and title	Certifying Nurs	e Practitioner:	To the best of n	ny knowledge,		at the time, ense numbe		ace, and due to		nd manner as s gned (Month, E		
	. \		DA76	Tak	Mil	198	CRNO		43201				25/1		
	15 / W		30. Name and address	s of person who c	ompleted caus	e of death (Item									
	1- 1		Debrah Mi					11 Rd	Rockv	ille,	MD 208	55			
	Stat Registra	_	31. Date filed (Month,	FEB 2 8	2012 N	egis ar's Signat	ure	ho. V.	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William 27,2012 Belsky 9:40A M February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13600 Devonfield Drive Baldwin Baltimore ocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, g. Birthplace (State or Foreign **Funeral** 215-16-5708 **Director** 1 🛛 M 2 🗆 F 90 Jan.16,1922 Philadelphia, PA Usual Residence of Decedent or 28a-f shov 10a. State filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baldwin 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 13600 Devonfield Drive Funeral 21013 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WWII 3 X Widowed 4 ☐ Divorced Completed Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Planner other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or care. 18. Mother's Name (First, Middle, Maiden Surname) Nicholas E. Belsky Antonina Yavorska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13600 Devonfield Drive Baldwin, MD 21013 Lisa Lenz-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 2, 1 ABurial 2 Cremation 3 Removal from State Parkville, Maryland Parkwood Cemetery 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Evans Fundral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate 1 Yes 2 No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be

within 2

24 hours

son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of ELOS

determined

7801 YOM Rd st 102 Towson MO 224

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

02-28-12

City or Town, State)

282012

4 Homicide

29a, Certifier

(Check

Registrar

1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 8 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physici Med Exam Funera Directo permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	101	aryland / Depa			ental Hygier	ne a n	ID DEDAL				
	State Registrar	Cer	tificate of De			No.Z U	12 05804				
an/ cai	Decedent's Name (First, Middle, Last) Bismillah	E	Begum		2. Date of Death Month 02 24	Day 20	79 3. Time of Death 12 5:14a. M				
ner	4a. Facility Name (if not institution, give street and number) 4054 Hobbs Hill Road		4b. City, Town, or Loc Glene	ation of Death		4c. County	of Death Howard				
	5. Social Security Number 219-19-3365 Usual Residence of Decedent 6. Sex 1	e (In yrs. last birthday) 84 Yrs.		ours Min.	8. Date of Birth (Month, Day, Yea) 28	27					
٥	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits				
Funeral Director	MD Howard	Glenel	Lg			1 ☐ Yes 2 ☐XNo					
al D	10e. Street and Number		10f. Zip Code		10g.	10g. Citizen of What Country?					
uner	4054 Hobbs Hill Road 11. Marital Status 12. Was Decedent B	Ever in II S 12 V	217		fu Van ar Na	_	S.A.				
Completed by Fi	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent € Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates.	.No	Vas Decedent of Hispa f Yes, specify Cuban, № □ Yes 2 🛣 No S	can, etc.)		ce - American Indian, ck, White, etc.					
olete	15. Decedent's Education (Specify only highest grade completed)	Jusiness/Industry									
mo	Elementary/Secondary (0-12) College (1-4 or 5										
BeC	12th grade na 17. Father's Name (First, Middle, Last) Unknown	ome									
일	Unknown		18	Mother's Name (First, Middle, Maid	en Surnam	e) Unknown				
	19a. Informant's Name/Relationship (Type, Print) Shahid Khan-Son		ng Address (Street and Paradise								
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	, ,	sition (Name of natory or other place)	Da			- City or Town, State				
	21. Signature of Funeral Service Licensee	M22	Name and Address of Arch F/H 300 Wabas	Facility West							
dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Be Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year				
by P	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given i	n Part I.			tribute to the cause of death?				
ted	Hypertension				1 Tes	2 No	3 Probably 4 Unknown				
Comple					24a. Was an autopsy performed	?/	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
Be (25. Was case referred to medical examiner?			of Death (Check o							
2	1 ☐ Yes 2 ☐ No Prospital: 1 ☐ Inpati 27. Manger of Death 28a. Date of inju	ent 2 ER/Outpatien			e 5 Residence						
cate	1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation	(, Year) Injury	work?	2 🗆 No	3d. Describe how in	ijury occurr	red				
Certifi	3 Suicide 6 Could not be	Iry - At home, farm, stre c. (Specify)	eet, factory, office	28	Bf. Location (Street City or Town, St		er or Rural Route Number,				
Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 3 Certifying Nurse Practitioner: To the	xamination and/or invest	igation, in my opinion, d	eath occurred at th	ne time, date and pla	ace, and du	e to the cause(s) and manner stated.				
	29b. Signature and title of certifier		29c. License nu	mber		Date signe	d (Month, Day, Year)				
	30. Name and address of person who completed cause of d		rint)	. 10			Bractimore MD2/20				
	ANWAR KINGKAM 31. Date filed (Month, Day, Year) 32. Registra	M D		NUTH EUM	W JT. #1	-7,1	DRICH IMOTE 1117 A/W				
te ar	EED o o dota	exern A.	parked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Donna Maria Baldwin Physician/ FEBRUARY 25 2012 2:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day,) Sept. 21 1 M 2XXF Months Hours 1942Balt. Maryland 216-42-7829 69 Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Timonium Baltimore 28a-f Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g Citizen of What Country? United States "natural", or items 23a or edical Examiner must be 21093 Funeral 12021 Trallee Road Unit 106 of America 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes ②XXNo Black, White, etc. þ 1 Never Married 2 X Married white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Inforciart: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical E once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Consultant Verizon 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Hess ည Joseph DiMarino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 12021 Trallee Rd. Unit 106 Timonium, Maryland 19a. Informant's Name/Relationship (Type, Print) Mr. Meares M. Baldwin, Jr./hus 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Evans Funeral Chapel – Bel Air 1 Burial 2 Cremation 3 Removal from State February 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 29, 2012 21. Signature of Fun / Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ percalos disease or condition resulting in death) hronic Medical Due to (or as a consequence Examiner muscular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Obstructive and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Obesi 1 Yes 2 No 3 Probably 4 Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Ŋ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 1 5 Pending death. Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Charlete marie D20907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Chorles St. 31. Date filed (Month, Day, Year) State FEB 28

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

racy Renee Britt		I- For State	tate of Maryla		epartment d C <i>ertificate</i> d		and	Mental	Hygie		2 U g. No.	1 4	0580
Physiciar	n/	Registrar 1. Decedent's Name (First, Mid	dle,Last)							ite of Death			3. Time of Death
Medical Examin	er	Tracy Re	enee Brit			4b. City, Tov	wn or lo	cation of De	Fe	bruary 2	3, 2012 4c. County of		1103 hrs
)		Baltimore Washingto				Glen B		22(10) 101 20			Anne Aru		
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under		If Under 24			(MM/DD/YYYY)	9. Birtl Foreigr	
Director	l	219-88-8894	1 M 2 X F	3	5 y	Months .	Days	Hours I	Min. 1	-15-	1977	Cou	ntry)MD
Au	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Loca	ation						\neg	10d, Inside City Limits
nd sibow a	<u> </u>	MD Cai	roll			Wes	tmi	nstei	<u>-</u>				1 X Yes 2 No
Maryland 28a-f shov il at once	Director	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of Wha	it Coun	try?
ith the Maryland 23a or 28a-f sho notified at once		102 W. Mair						157			USA		
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Never Married 2	12. Was Dec	orces?	If	as Decedent Yes, specify (14. Race - White,		an Indian, Black,
fter de		3 Widowed 4 Di	vorced If Yes, Give Yes	2 X N	1 _	Yes 2X	No s	pecify:			Specify: V	vhi	te
hours a	ed by	15. Decedent's Education (Sp				nt's Usual Oc nost of workin				one	16b. Kind of Busi	ness/In	dustry
36 nin 72 e. than "	Completed	Elementary/Secondary (0-12 1 2) College (1	-4 or 5+)		ker					Cookin	ıg	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	탕	17. Father's Name (First, Middle	e, Last)	-			18.	Mother's Na	me (First,	, Middle, Ma	aiden Surname)		
d be fill fental H	8	Charles I		n	The H			Wanda				200	
MD 2 d 2 shoul th and N n 27 is m] د	Wanda Britto		-							estmins		Zip Code) 21157
e, N I and I Health item	ŀ	20a. Method of Disposition		20	0b. Place of Dispo crematory or o	sition (Name			Date		20c. Location - C		·
Pages nent of unt: If		1 Burial 2 X Crematic	n 3 ∐ Removal fr Specifv:	om State	South C	arrol							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Ī	Donation 5 Other S 21. Signatur of Funeral Service	License	777	22.	Name and Ad	dress of	Facility F	Letc	her	Funera	H	ome
Physician	+	23a. Part I. Enter the disease, o	r complications that c	aused the de							nster, N st, shock, or hear		Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		umor									Between Onset and Death
Adminer	ł	or condition resulting in death)	Due to (or as a		ce of):								•
		Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequenc	ce of):								
	E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	ce of):								
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6876 certificate nding phy	ΣL	IF FEMALE: 3b. Was decedent pregnant in tage past 12 months?		outcome of p irth		etal death	3 🔲	Ectopic preg	gnancy		23d. Date of do Month	elivery Da	ay Year
Box 6876(c death certificate the attending physed for use as the b	5 I	1 Yes 2 No 9 ✔ Ur		ant at time o	of death 5 🗌 C	ther (Specify)						0
the d		Part II. Other significant condi	3 Olikik		ot resulting in the	underlying ca	ause give	n in Part I.	2	3e. Did tob	acco use contribu	ute to th	ne cause of death?
i, P.O.	ğ								_	1 Yes	2 No 3	Proba	ibly 4 🗹 Unknown
Cords, law requir has been s	Сотрыетед								_ 2	4a. Was er autopsy	/ pri	or to co	ppsy findings available mpletion of cause of
Reco	Ę								1[yerform ✓ Yes 2		ath? ✔ Yes	2 No
Vital Rec ysician: The his certificate director, page	ě	25. Was case referred to medical examiner?	(Lease No. 1)					Death (Chedera)		<u> </u>		211	
n of Viding Physical After this funeral direction.	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	✓ ER/Outpatien 28b. Time of		. Injury a				esidence 6	Other:	
ion creating eath. Ior: At the fur			ding estigation (Month	Day,Year)		1	Yes	2 No					
Division of Vital Records, tal or Attending Physician: The law require rather death. al Director: After this certificate has been similarly in by the funeral director, page 2 should be defined in by the funeral director, page 2 should be defined in the Definition of the definition	Certification:	3 Suicide 6 Cou	ld not be 28e. Place	e of Injury - A	At home, farm, stre	et, factory, of	fice build	ing, etc.		ocation (Str		or Rura	al Route Number, City
Divi		4 Homicide 29a. Certifier	ermined (Specify)							41			
Division To the Hospital or Attendi within 24 hours after death, wither Funeral Director: \(\) completely filled in by the fill manifectely filled in by the filled in th	١٥١	Check only	hysician: To the bes iminer: On the basis of and manner si	of examination									
	2	29b. Signature and title of certifi		utou.			icense nu				29d. Date signed	(Mont	h, Day, Year)
		Hancet 9 rue	thall m	0		c	D.C.M.E				February 24,	2012	2
Ø		30. Name and address of person Pamela E. Southall, N	· · · · · · · · · · · · · · · · · · ·			0 W. Baltir	more S	treet, Ba	ltimore	, MD 212	223		
Stat	e	31. Date fire Bridge 8, Vear		gistrar's Sigr						-			
Registra	ar	· FD - O 20	16 Consein	<u> </u>	- South	1							

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AMEND ITEM#10a-f.perINF.G925.3/1/2012.WS
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11:02 AM Physician/ Bain Vernice Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** University of Maryland Baltimore Medical Cer If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 20, 1958 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-76-0998 Wash. DC 53 Director 1 □ M 2√ F 10c. City, Town or Location 1e Hills Washington 28a-f shov 10d. Inside City Limits 10a. State items 23a or 28a-f sho her must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 X No -DC-MD PG 10f. Zip Code 20748 10e. Street and Number 4649 Dallas Pl. #103 10g. Citizen of What Country? 20032 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ıral", or iten Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any piury or other traumatic event, the Medical
once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Paralegal Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ McCullum Elizabeth Bain James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Glendora Dr. District Heights, MD 20747 19a. Informant's Name/Relationship (Type, Print) Brian Bain/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 【 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-5-2012 Laurel, MD MD National Cemetery! 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licens 10583 Middleport Ln. White Plains, MD 20695 Koma 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final te piradoru Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ardiac Arch 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes has been signed to should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending Director: A id in by the fi ☐ Accident ☐ Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Designing Financian. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number ပ 2012 213157 Ellen and address of person who completed cause of death (Item 23a) (Type, Print) MD Baltimore ou Ellen L South 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

FEB 2 8 2012

12-01449 Ziyheem Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 05808

		1- For State Registrar			Cert	ificate o	f Death			F	Reg. No.		
Physici edical Exami	an/	Decedent's Name (First, Middle	st, Middle,Last) 2. Date of Death Month Day Year								Year	3. Time of Death 1703 hrs	
edicai Exami	nei	Ziyheem Amarı 4a. Facility Name (if not institution	em Amaru-Foreman Baker February 18, 2012 ne (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of									ity of Deal	h
		Bowie Health Center					Bowie					e Georg	
Funeral Director		5. Social Security Number 825–28–8816	6. Sex		e (In yrs. las	st birthday) Yrs	If Under 1 Your Months Day 2.5	ys Hour		1	- 2012	YY) 9. Bi Forei C	rthplace (State or ign MD ountry)
		Usual Residence of Decedent			10.00								10d. Inside City Limits
0 4		10a. State 10b. County			· ·	Town or Local							1 Yes 2 No
Aaryland 28a-f show 1 at ooce	ģ	MD P.G. 10e. Street and Number			Uppe	er Ma	rlboro Tiof, Zip Code	_			10g. Citizen of	What Cor	21
th the Maryland 23a or 28a-f sho ootified at ooce	Director	12805 Winon	a Dr				20774			i	U.S.A.		•
s 23s e ooti	ᇛ	11. Marital Status		Vas Decedent	Ever in U.S		as Decedent of I			cify Yes or N	o- 14. Ra	ace - Ame	rican Indian, Black,
death r item	Funeral	1 Never Married 2 Ma	arried A	rmed Forces?	X No	lf \	es, specify Cub	an, Mexicai	n, Puerto R	tican, etc.)		/hite, etc.	als
after	by F		orced if Yes, or Date	es:		1	Yes 2X					Bla	
hours natur Exam		15. Decedent's Education (Spec		est grade com ollege (1-4 or 5	,	16a. Decedei during n	nt's Usual Occup nost of working I	eation (Give fe. DO NO	kind of wo Tuse retire	aN/A	16b. Kind of	Business	/Indust N / A
, MD 21215-0036 cand 2 should Hige within 72 hours after death with the Maryland cand A Montab Higes within 72 hours after death with the Maryland tem 21 is marked other than "natural", or items 23a or 28a-1 sh traumatic event, the Medical Examiner must be sotified at occ	Completed	Elementary/Secondary (0-12)		niege (1-4 or s)								
5-0036 led within 72 Hygiene. lother than	S	17. Father's Name (First, Middle,	Last)					18.Mothe	er's Name (First, Middle,	Maiden Surna	me)	
21215-0036 and be filed within ? Mental Hygiene. marked other than	Be	Adrian Pres			le B						Forema		
nore, MD 21215-003 nt of should be filed withi nt of Health and Mortal Hygiene. f: If item 27 is marked other th other traumatic event, the Med	P	19a. Informant's Name/Relations				1	g Address (Str						
ore, MD ss 1 and 2 sho of Health and fritem 27 in her traumat		Rashida Ann F 20a. Method of Disposition	<u>orema</u>	in/Mot	:her 20b. Pl	11 2 8 0 Place of Dispos	Sition (Name of	a Dr emetery,	- Upr	Der Ma	20c. Location	on - City o) 2 0 7 7 4 r Town, State
		1 Burial 2 Cremation	3 Ren	noval from Sta	ate cr	ematory or of	ther place)						
.트 a a a a b	- 1	4 Donation 5 Other Sp 21 Signature of Funeral Service		_	TKT	22. i	Name and Addre	ss of Facili	tyRona	ald T	aylor	II	,MD FuneralHm.
Balti permit. Departr Import iojury		-Kroundel (Drel.	211									
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complication	s that caused	the death. I	Do not enter	the mode of dyir	g, such as	cardiac or	respiratory a	rest, shock, or	Heart	oximate I e a Between Onset and
Medical Examiner	- 1	Immediate Cause (Final disease		te Pnei	umonia	3							Death
,-Xa		or condition resulting in death)	Due to	(or as a conse	equence of)								
	-	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conse	equence of)	:							
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	C. Duo to	(or as a conse	equence of								-14
cuted and transit		events resulting in death) Last	d.	(01 43 4 00130	equence or,								
an exe	/Medical	X UNPENDED	AME	NDED 23a	,27,p	er me,	g926 4-	25-12	SIL	••			
	/Me	IF FEMALE: 23b, Was decedent pregnant in th	23c.	. If yes, outcor	ne of pregn	ancy						e of delive	
Box 687 ne death certification the attending	cian	past 12 months?		Live birth Pregnant at		the contract	etal death ther (Specify)	sEctop	oic pregnan	cy	Monti	1	Day Year
Box 68 e death certification the attending ed for use as	Physician	1 Yes 2 No 9 Uni	known 9	Unknown		• _ 0	tiei (epeciny)						
ires that the signed by the detache	by Pi	Part ii. Other significant condit	ions contrib	buting to death	h but not res	sulting in the	underlying caus	e given in F	Part I.				the cause of death? bably 4 Unknown
S, P uires t n sign Id be c										24a. Wa			autopsy findings available
cords, law requir has been s	plet									auto	opsy formed?		completion of cause of
Rec The la icate h	Completed									1 Yes	2 No	1 🗸 Y	
tal Recition: The certificate rector, page	Be (25. Was case referred to medica examiner?	l Hospital	E I I I I I I I I I I I I I I I I I I I				Other,			Residence	6 Oth	
f Vi Physic er this eral dir	ဥ	1 Yes 2 No 27. Manner of Death		1 Inpatie		ER/Outpatien		njury at Wo			how injury oc		ei.
Division of Vital Records, tall or Attending Physician: The law requiring that dear dear. After this certificate has been seled in by the funeral director, page 2 should it	Certification:	1 X Natural 5 Pend		(Month, Day,Y	'ear)		· · · _	Yes 2	_ 1				
r Atte r Atte ter dez irecto n by th	fical		stigation 28	Be. Place of In	njury - At ho	me, farm, stre	et, factory, offic	e building,	etc.			ımber or F	Rural Route Number, City
Divis pital or At ours after d neral Direct	èri			Specify)						or Town,			
Division To the Hospital or Atteod within 24 hours after death To the Funeral Director:		(nysician: To	the best of m	y knowledg	e, death occu	urred at the time	date and p	lace, and o	due to the car	use(s) and mar	nner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	2 Medical Exa 29b. Signature and title of certific	and m	anner stated.	mination an	id/or investiga		nse numbe					onth, Day, Year)
	2	29b. Signature and title of certifie	11	2				C.M.E.			Februar		
1		30. Name and address of person	Mho comple	ted cause of a	leath (Item	23a)							
Q							Baltimore S	treet, Ba	ltimore,	MD 2122	3		
	tate	31. Date filed (Month, Day, Year)	-	32. Registra		re							
Regis	trar	FEB 2 8 2012	2	were .	B. A	Berke							
DHMH 17 Rev 1/2	2001		,			ORIGINA	AL				00	ME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carl Albert Balcerak 4: 05PM eloma Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Hospital Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) **Director** 054-14-7884 90 1 X M 2 □ F 05/04/1921 New York Usual Residence of Decedent 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f s aumatic event, the Medical Examiner must be notified 1 Yes 2 No Maryland | Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 272 West Pasadena Road 21108 U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 💢 No Specify: White 3 Widowed 4 Divorced Specify. Completed 1943-45 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Journalist Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic enonce. ပ Valentine Balcerak Michaeline Graczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Kahle/Friend 13-C President Point Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3/2/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ICE MI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examir burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ page 2 should be detached for in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death. Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 1 Inpatient 2 [ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License number person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month February 2012 8:30am M DUSCOMI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Svkesville 2413 Haight Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7 Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days Min Nov. 14, Year) 1949 Country) 1 □ M 2 ⋤ F MD Director 215-54-3244 62 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 2413 Haight Avenue 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2X Married 1 Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Social Security Admin Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn Pradich William Holden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 Haight Avenue Sykesville, MD 21784 Mr. Paul C. Buscemi (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/2012 All County Cremation Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses Duan MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause projects in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 UNO 1 L Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Hospita Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Þ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ter St. Westminster

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 0420 PM 24 2012 Lazzette Fay Beachlev Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WACHINGTON MEDILAL ANNE I HOURNIE GLER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months Hours (Month, Day, Year) 213-20-7066 Director 1 □ M 2 🗓 F 88 08/06/1923 Pennsylvania Usual Residence of Deceden r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD Linthicum Heights 1 ☐ Yes X☐ No Anne Arundel Co 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 517 Cleveland Road 21090 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White "natural", 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည George W. Bender Myrtle L. Stuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tranonce. Mr. Robert J. Beachley, Jr./son 477 Yorkshire Drive Severna Park, MD 21146 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1XXBurial 2 Cremation 3 Removal from State 2/29/2012 Meadowridge Mem. Park Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STACE CHRONIC OBSTRICTIVE KULMONIARY disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atter should be detached for a in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has page 2 I or Attending Physician: The after death.

Director: After this certificate h 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records, P.O. Box 68760 To the Hospital

certificate be

Baltimore, Maryland 21215-0036

State Registrar

Date filed (Month Da

only one)

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Physician/ BERRONG Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner SURNIE WNCUTRUDET Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 69 Director 439-58-7383 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director MD 1 Yes XX No Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 USA 256 Glenda Court items 2 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces?

1xxx Yes 2 \quad No Black, White, etc. ģ 1 Never Married XX Married Types Yes Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Command Sergeant Major US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis G. Woodward J. Miles Berrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, MD 256 Glenda Court Mrs. Judy Berrong / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National UNK Arlington, VA permit. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 10: 23a, Part 1. Enter the disease er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Year 5 Other (specify) Day Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I for the Funeral Director, here funeral director, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature 29d. Date signed (Month, Day, Year) 0 2012

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bealty Physician/ JOYCE February 7.3 2012 128 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice at Northwest Hospital Randallstown Baltimore Co. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 213-52-4571 1 □ M 2 耳F 62 11/22/1949 Maryland Usual Residence of Deced 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Halethorpe 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 2400 Alma Road 21227 United States items within 72 hours after death ı "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 - Widowed 4 X Divorced Specify: White er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9_yrs. Retail other 1 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ၉ John Lanham Dolores Doering traumatic Page 1 and 2 should I ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ms. Kelly L. Schlothauer/Daughter 2400 Alma Road Halethorpe, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Atlantic Crematory 02/25/2012 Glen Burnie, MD Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cancer Breast disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examiner Due to (or as a consequence of) if any leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed burial-trar the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2. No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 \(\subseteq \text{Yes} \) 2 No s after death filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns Rajapahe M.D 2/24/12 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N : S RYMPALL M'D 2835 Sm: Th D Baltimore 21209, 203 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G924, 2/2872012, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 05814 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year (27 AM BASS February SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Daltimore Baltimore 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2 🏿 F Days 06/30/1937 Min 216-34-9478 74 Yrs. **Director** MD Usual Residence of Decedent 28a-f show 10a. State 10b. County artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4249 LABYRINTH ROAD 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russo 2 THOMAS BASS LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4249 LABYRINTH ROAD, BALTIMORE, MD TAMMY BASS / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
MIKRO KODESH
BETH ISRAEL CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/27/2012 BALTIMORE, MD 21. Signature of Juneral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Esophagea Ph sician 1.5 years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by thrombor 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tebruary 25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Francis Sinal emoth 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day 22 Physician/ Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4c. County of Deat Northwest and all stown, MI Hispital Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) M 2 □ F Month, Day, 59 Yrs. Director 218-56-2245 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a Funeral 6 BIRCH BARK COURT 21117 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. "natural", Completed 3 Widowed 4 X Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filled within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PHARMACIST PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM BLUMENFELD HATTIE BLUMBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE CAPLAN-STADD / SISTER 6350 RED CEDAR PLACE, #311, BALTIMORE, MD 21209 Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of I 1 X Burial 2 Cremation 3 Removal from State injury (BALTIMORE HEBREW CONG 02/26/2012 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., alu/e of Funeral Service Lice so . Siu 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responded, or heart failure. List only one cause on each line. atory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 5 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sho Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
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1 Yes 2 No 24a. Was an After this certificate has autopsy performe . Yes 2 X No 25. Was case referred to medical examiner?

1 ₩ Yes 2 □ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 No Yes P ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Mariner of Death 28c. Injury at work?
_1 ☐ Yes 2 ▼No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Di Year) 1 Natural 5 Pending Selfinfliced gun shot 28f. Location (Street and Number or Rural Route Number City or Town, Statel & Birch Bank CT. Owings MILLS Md 21117 22/2012 Accident Investigation un Know N 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined tome Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifier 29d. Date signed (Month), 30. Name and address of person who completed cause of death (Ite one 31. Date filed (Month, Day, Year) FEB 2 8 2012 2. Registrar's Sign State

Registrar

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Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	ale of Beatif	Reg	g. No.	3. Time of Death
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		432 S. Hanover Street	Baltimore	To a	N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Mi	n.	n(MM/DD/YYYY) 9. Birt Foreig	nplace (State or MARYLAND Intry)
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Any		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
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Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
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Baltimore, Mi permit. Pages 1 and 2 s Department of Health a Important: If item 27		20a. Method of Disposition 20b. Place of	f Disposition (Name of cemetery, ory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		Donal 2 Michigan Companion State		-27-12	BALTIMORE,	MARYLAND
talti mit. spartm		21. Signatur of Them Strike teensee	22 Name and Address of Facility N	OMMUNITY	FUNERAL HO	ME P.A.
	V W	23a. Part LEnterthe disease, or complications that caused the death. Do no	1 1206 W NORTH AVEN	UE		
Physician Medical	8 9	failure. List only one cause on each line.		or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death
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Division rate of an arte of a by the full of the full	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far	m, street, factory, office building, etc.		reet and Number or Rur ate) r Street, Baltimore, N	
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DIVIS To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in				
To viti	Mec	and manner stated. 29b. Signature and title of certifier	29c, License number		29d. Date signed (Mon	
		The With To	O.C.M.E.	ICME	February 25, 201	2
		30. Name and address of person who completed cause of death (Item 23a)	~ ,			
		Theodore M. King, Jr., MD. Assistant Medical Exami	ner 900 W. Baltimore Street, E	Baltimore, MD	21223	
St Regist	ate	31. Date filed (Month, Day, Year) FEB 2 8 2012	who			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25, 2012 Ellen Moy Chu Feb. 4:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4801 Hampden Lane #403 Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 133-30-1975 Usual Residence of Dece 1 □ M 2**X** F 73 April 7,1938 New York 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Bethesda Montgomery 1 Yes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 4801 Hampden Lane #403 20814 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 1 Never Married 2 X Married þ hours after Yes 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Asian "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Librarian Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wong Nie Moy Yik Foon Chin Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Hampden Lane #403 Bethesda, MD 20814 Sherwood C. Chu / husband Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/28/12 Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service, P.O. Box784 Beverly L. Heckrotte, P.A. Clarksville, M 112 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 months Immediate Cause (Final Physician/ disease or condition Lung Cancer) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2X 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signalure and title of cer 29c. License number 29d. Date signed (Month, Day, Year, 67258 2/27/12

DHMH 17 Rev 06-2011

State

Registrar

Nicholas Ferrell 9707 Medical Center Drive Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ February 2012 Susan Ann Clarke 1:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chespeake Hospital Harford Air If Under 1 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 2,1958 Months Days Hours Min Maryland 216-76-1223 Director 1 □ M 2 💢 F 53 Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 😾 No Maryland Harford Street 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? ō Funeral 3430 21154 Conowingo Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? ь 1 X Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ge 1 and 2 should be filed within 7 it of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine Anna Szimanski Robert Eugene Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Christopher W. Clarke:Son 3430 Conowingo Road, Street, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, Ardent Cremation, Inc. 2-24-12 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metastatic Onset and Death Immediate Cause (Final Breast Concer Physician/ one year disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of Due to (or as a consequence of): resulting in death) Last 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier соmpletely (Chec Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only c 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) February 22nd 2012 D 45390 m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

My O Min (h.D.) 570 Lyper Chesapeake Drive # 407, Bel Air, MD 21014

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Month Margaret Criswell 7:30 PM Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center Prince George's Adeiphi Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 8 Date of Birth Funeral (Month, Day, Days Hours Min 089-12-2292 89 Brook1 Director Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Tyes 2x No NY Kings Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8301 Ridge Blvd. 11209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: "natural", Specify: White Completed 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christopher Byrnes Margaret Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Stephen Criswell - Son 8037 Crest Road Laurel, MD 20723 Baltimore, 20a. Method of Disposition
1 □ Burial 2 🎦 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Greenwood 2-27-12 4 Donation 5 Other (Specify) Crematory Brooklyn, NY 22. Name and Address of Facility Metropolitan Funeral Service Su ature of Funeral Service Licensee 5517 Vine St. Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami partenscon Due to or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical law requires that the death certificate be P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death the Unknown 9 Unknown is been signed by the should be detached Part II. **Othe<u>r</u> significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 page this certificate 1 Yes 2 No To the Hospital or Attending Physician: Division of Vital 25. Was case referre to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 2 **1** No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 and the of certifie 29b. Signature 47867

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)
Oney Zuniga, MD 4701 Randolph Road Suite 101 Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla				and M	ental Hy	giene	010	05000
			1 - State Registrar Certificate of Death Reg. No. 2								2012	05820
	Physicia	m/	1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea		Voor	3. Time of Death
	Medic		Mary	A. Clevelan	d				Februa	ry 25	2012	9:28 P M
	Examin	er	4a. Facility Name (if not institution, giv			4b. City, Town, or				4c. County of Death		
and the			14025 Manches			Upper 1					ince Ge	
	Funeral Director				last birthday)	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt 7/26/1		9. Birth Cour	olace (State or Foreign htry)
			213-26-0503 Usual Residence of Decedent	1 □ M 2 X F 85	Yrs.				//20/1	920	Mary	land
	and shov	5	10a. State 10b. County	10c. C	ity, Town or Lo	cation						0d. Inside City Limits
	Maryl 8a-f rtified	lec	MD Prince	George's	Upper N	iarlboro						1X Yes 2 ☐ No
	the I	Ö	10e. Street and Number	20180	<u>UPPUL</u>	10f. Zip Code				10g. Citize	n of What Cou	ntry?
	s 23	Funeral Director	14025 Manchest	er Road		2077	4			USA		
	death item ier n	Fur	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Ori	igin? (Spec	ify Yes or No-	14	Race - Americ	
9	after ", or camir	l by	1 Never Married 2 Married	1 ☐ Yes 2 🌠 No If Yes, Give		☐ Yes 2 🏋 No			,,	Sr	Black, White, becify: B1	
3	ours a	Completed	3 X Widowed 4 Divorced 15. Decedent's	Year or Dates.								
ဂ	72 h n "na Aedi c	nple	(Specify only highest g	rade completed)	(Give	lent's Usual Occup kind of work done (O NOT use retired)		t of working	9	16b. Kind	of Business/In	dustry
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ַ	iled v Il Hyg othe vent,	Be	17. Father's Name (First, Middle, Last)		1 0001		18. Moth	er's Name	(First, Middle,			
<u>lar</u>	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "hatural", or items 23a or 28a-f show is marked other than "tatural".	To.	Grady Heath					Flore	ence G.	Mul]	en	
a D	shoulk and N is ma		19a. Informant's Name/Relationship (**	19b. Mailir	g Address (Street a	and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Zip (Code) 20774
Σ	nd 2 sealth n 27 er tra		Joseph N. Cleve	land Sr.	1402	25 Manche	ster	Road	Upper	Marlb	oro, Ma	aryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 [20b.	Place of Dispo	sition (Name of natory or other plac	ce)	Da	ate	20c. Loca	ation - City or To	own, State
Ĕ	Page ment tant; ury o		4 Donation 5 Other (Spec	ify) Li		Cemetery		3/5/2	2012	Suit1	and,Mar	yland
Sa E	permit Depart Impor any in once.		21. Signature of Funeral Service Licer	kee //								HOME, INC.
_	0 □ = @ O		K.D. 19-1	all							, Mary	land 20785
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea one cause on each line.	ath. Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Phylician	8	Immediate Cause (Final disease or condition	_a_Anemia							3	Onset and Death
أرسد	Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
		e	Sequentially list conditions, if any, leading to immediate	b. Failure to Due to (or as a conse								
	ed	Examiner	Cause (Disease or injury	· · · · · · · · · · · · · · · · · ·		1						
	xecut al-tra	Exa	that initiated events resulting in death) Last	c. Myelopthis Due to (or as a conse	quence of):	order						
20	cate be executed physician and sthe burial-transit	dical		d. Parkinson'	s Disea	ase						
08/0	ficate g phy as the	Jed										
ĕ	n certi endin r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnanc	°V			23	d. Date of deliv	ery
POX	death	sici	in the past 12 months?	4 Pregnant at time of		Other (specify)	· y				Month	Day Year
	t the by the	Physician/Me	g ☐ Unknown Part II. Other significant conditions		aultine in the u	adauli in - agusa -ir	ion in Dort		20 0111			
J.	es tha ignec be d	by	Part II. Other significant conditions	solution to death but not re	ssutting in the d	ndenying cause git	/elillirait	1.				ne cause of death?
g	equire een s hould	eted										pably 4 🗌 Unknown
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ř	: The cate r, pag						_		1 🗆 Yes	rmed? 2 🔀 No	1 Yes	2 🗆 No
<u> </u>	sician certif recto	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Tothe	or.	th (Check o				
01	Phys r this eral d	: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	J ER/Outpatier 28b. Time of	t 3 L DOA 28c. Injun	4 L. Nu		e 5 🖎 Resid d. Describe h		Other (Specify)
Z O	nding tth. : Afte e fun	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 🗌		. D 0001120 11	on injury o	oodiiioo	
DIVISION	Atter	Certificate:	3 Suicide 6 Could not	be 28e. Place of Injury - At I		eet, factory, office		2			lumber or Rura	Route Number,
_	tal or			building, etc. (Speci	Ty)				City or Tow	n, State)		
	lospi 4 hou uner ely fil	Medical		ysician: To the best of my knowniner: On the basis of examinati								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Differ to the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me		rse Practitioner: To the best of		death occurred at t	he time, da		e, and due to the	ne cause(s)	and manner as	stated.
	5 ≥ 5 8		1	110		29c. License					signed (Month,	
	ron		30. Name and address of verson who	completed cause of death fits	m 23a) /Tuna - F	D2278	υ			rebr	uary 27	, ∠∪1∠
	50		Peter Schissler		, , , , ,		re #4:	30 Gr	eenbel	t, Ma	ryland	20770
	Stat	te	31. Date filed (Month Day, Year) 7 PEB 2 8 20								-	
	Registra	ar	LED % 9 50	12 3. Registrar's Sign	a. Apa	ver						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aonth Day Day 19 28/2 Physician/ Joseph Anthony Chinskey Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 212-50-0806 Director 1 🖾 M 2 🗆 F May 1, 1947 Maryland Yrs. 64 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County with the Maryland Director notified 1 Yes 2X No Baltimore Baltimore Maryland | 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral USA 21206 4015 Frankford Ave. items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. þ ō 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Supply Company Supply Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fortuna Josephine Maggio မ Joseph Anthony Chinskey Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Cagney Ct., Bel Air, Maryland 21014 John P. Chinskey / Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, XBurial 2 ☐ Cremation 3 ☐ Removal from State 2-27-2012 Baltimore, Maryland Donation 5 Other (Specify) Holv Redeemer Cem Scripture of Ineral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility March a 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or shock, or heart failure. List only mp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Neuro endocribe disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Dav Pregnant at time of death the a 1 Yes 2 No signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) THIL HOSPI'C 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 \(\text{Yes} \) 2 \(\text{No} \) No after death.

Director: Af Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 934 Auration Blud

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 24 Physician/ FEBRUARY 02:04 P M PHILIP C. COHEN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL BALTIMORE CITY N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1**X** M 2 □ F Min. 55 0377171956 002-40-6575 **Director** MA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE REISTERSTOWN 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12521 VALLEY PINES DRIVE 21136 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify WHITE "natural" Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MARYLAND College (1-4 or 5+) Elementary/Seconday (0-12) STADIUM AUTHORITY ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ CLATRE FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN COHEN/WIFE 12521 VALLEY PINES DRIVE REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗆 Other (Specify) BETH EL MEM. PARK 02/26/2012 RANDALLSTOWN, MD 21. Signature of Funeral Ser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: 1 Yes 2 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 100 Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ð HER ORISKER 2750 Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of L		Reg.	No. 2012	2 0582
Physic Medical Exam				2. Date of Death Month D	av Year	3. Time of Death 1055 hrs
		4a. Facility Name (if not institution, give street and number) 4b	. City, Town, or Location of Death	February 22	4c. County of Death	
1			Bethesda	To para april a	Montgomery	1 (2)
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F Usual Residence of Decedent	If Under 1 Year If Under 24Hrs Months Days Hours Min.	May 21,	MM/DD/YYYY) 9. Birti 1967 Foreigr Cou	nplace (State or Taiwan ntry)
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once,	Į.	Maryland Montgomery Derw	ood			1 Yes 2 X No
Mary or 28a-	Director	10e. Street and Number	10f. Zip Code		Citizen of What Count	
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	ם	· · · · · · · · · · · · · · · · · · ·	20855 Decedent of Hispanic Origin? (Sp		nited Stat	
5-0036 led within 72 hours after death with the Maryland 'tygene. other than "natural", or items 23a or 28a-f shu the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed Forces? If Yes 1 Yes 2 X No	, specify Cuban, Mexican, Puerto		White, etc.	arr main, prast,
s after iral",	5	3 Widowed 4 Divorced III Yes, Give Year 1 Yes	es 2 X No specify: Usual Occupation (Give kind of w	and dans lat		sian
72 hours 1 "natu:	eted	Elementary/Secondary (0-12) College (1-4 or 5+) Clinical	t of working life. DO NOT use retir 1 Technologist	red)	6b. Kind of Business/In	austry
0036 within within cene.	Completed	5+ Supervi	sor		Clinical R	esearch
	Be Co		18.Mother's Name Sheu-O	(First, Middle, Mai	den Surname)	
imore, MD 2121 Pages I and 2 should be fil ment of Health and Mental I lant: Uitem 27 is marked or other traumatic event,	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or R	Rural Route Numbe		
MD and 2 she alth and 27 is aumat			ttenbrook Terra			
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State crematory or other	place) Ma:	rch 1,	Oc. Location - City or T	
Iltim nit. Pa artmen ortant		4 Donation 5 Other Specify:			Bethesda,	
Dep Dep Imp		Molarate Burnest Mola05 7557	rt A. Pumphrey Fune Wisconsin Avenue,	Bethesda, N	Maryland 2081	y Chase, Inc. 4-3501
Physician /Medical		23a. Part / Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.				Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosc Due to (or as a consequence of):	erotic Cardiova	ascular D	isease	Death
	_	Sequentially list conditions, b				
	Examiner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c				
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760, ficate be g physic the bur			2 🗆	_	23d. Date of delivery	<u> </u>
Box 687 The death certification is the attending property and the action of the actio	iciar	past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic pregnar (Specify)	ncy	Month Da	ay Year
the dear	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the und	arlying cause aiven in Part I	23a Did tahar	cco use contribute to the	no cause of death?
F, P.O. ires that the signed by	ğ		silying cause given in Fait i.		2 No 3 Proba	
ords, w requir s been s	ompleted			24a. Was an autopsy		ppsy findings available mpletion of cause of
Reco The law cate has	omo			performe 1 V Yes 2	d? death?	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check of DOA Other, Nursing			
of Viring Physical After this funeral dir	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		g Home 5 Res 28d. Describe how	sidence 6 Other:	
ion (tending eath.	cation	1 🔀 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law require stand or Attending Physician: The law require all birccore. After this certificate has been sited in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	Certific	3 Suicide 6 Could not be determined (Specify)	actory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rura	al Route Number, City
Hospita 4 hours			at the time, date and place, and	due to the cause/s) and manner as stated	1
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Paracra Director. After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as d	Medical	(check only one) 2				
	ž	29b. Signature and title of certifier	29c License number	MARE	9d. Date signed (Mont.	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	F	ebruary 23, 2012	:
7		Theodore M. King, Jr., MD. Assistant Medical Examiner 90	0 W. Baltimore Street, Ba	altimore, MD 2	1223	
			,	-		-
Regis	nigii	LLD A O COIL COMPANY TO THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	epartment of Health and M	lental Hyg	jiene	05021.
		_		Certificate of Death	R	Reg. No. 4 U 2	05824
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Deat Month		3. Time of Death
	Medic	al	Michael Ray Deruiter		Februar	y 20 2012	11:33 A ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	
	Funeral		90 Waverly Drive, Apt. X-102 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Frederick (av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Freder	TICK thplace (State or Foreign
	Director		228 02 4102 1⊠M 2□F v	Months Days Hours Min.	(Month, Day,	Year) Co	untry)
	, MC	Y.	Usual Residence of Decedent 50		Sept. 3	, 1961 V	irginia
	yland -f she ied at	ctor	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits
	e Mar r 28a notifi	Dire	Maryland Frederick Fre	derick 10f. Zip Code			1 🔀 Yes 2 □ No
	vith th	rai	90 Waverly Drive, Apt. X-102	21702		10g. Citizen of What Co United	•
	ems	Funeral Director		13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	
9	ter de , or it ımine	by F	1 Me Never Married 2 L Married 1 Married 2 No l		Rican, etc.)	Black, Whit	e, etc.
2	urs af ural", Il Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1980–85	1 ☐ Yes 2 🔀 No Specify:		Specify: W	nite
2	72 hol "nat edica	Completed	(Specify only highest grade completed) ((ecedent's Usual Occupation Give kind of work done during most of workir	ng	16b. Kind of Business	Industry (Industry
7	ithin ene. thar the M	Con	Elementary/Secondary (U-12) Gollege (1-4 or 5+)	e. DO NOT use retired) Inventory Clerk		Auto Salv	7200
O N	led w Hygi othe ent, t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N		age
lan	l be fi fental rked tic ev	P	William DeRuiter	Fran Far	is	,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)		Route Number,	City or Town, State, Zij	o Code)
	nd 2 s ealth m 27			Frog Hollow Road Eas	st Lyme	CT 06333	
Baltimore,	ela tofH lfitel or oth		1 Burial 2 Cremation 3 Removal from State cemetery,	crematory or other place)		20c. Location - City or	Town, State
Ē	t. Pag tment tant: tjury o		4 □ Donation 5 □ Other (Specify) Final C	Journey Crematory 2/2	24/12	Woodbine,	MD
Rai	permit. Page 1 a Department of F Important: If its any injury or ot		21. Signature of Funeral Service Licensee M01651	Going Home Cremation	on Servi	ice P.O. Bo	x 784
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not	Beverly L. Heckrot			Le, MD 21797 Approximate
	Discolation /		shock, or heart failure. List only one cause on each line.		, respiratory unit		Interval Between Onset and Death
	Physician/ Medical	1	disease or condition resulting in death) a. Due to (or as a consequence of)	ter Distant			unleasing
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		iner	Sequentially list conditions, it any, teaching to immediate cause. Enter Underlying				
	outed nd transi	Examiner	Cause (Disease or injury that initiated events c.				
	ate be executed hysician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence of).				
20	ate bo	dical	d				
200	ding se as	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Data of da	livon
ROX	atten atten i for u	iciar	in the past 12 months? 1 Live Birth 2 Fetal death 1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Day Year
n	the de sy the achec	Physician/Me	9 Unknown				
7. Ö.	that ned b	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
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co	aw re as be 2 sh	Completed			24a. Was ar autops	sy prior to	topsy findings available completion of cause of
Y Y	The I	S			perform 1 \sum Yes	med? death? 2 No 1 Yes	2 1 No
vital Records,	ician: sertific ector	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)		
01	Phys this ral dii	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp 27. Manger of Death 28a. Date of injury 28b. Tim	atient 3 L DOA 4 L Nursing Hor		ence 6 C Other (Spec w injury occurred	ify)
n O	ding th. After	Certificate:	1 Natural 5 Pending (Month, Day, Year) inju		ou. Describe no	w injury occurred	
UNISION	Atter er dea ector by th	ΪŢ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office		reet and Number or Ru	ral Route Number,
2	tal or rs after al Dir		building, etc. (Specify)		City or Town	i, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	the i	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowle 29b. Signature and title of certifier	dge, death occurred at the time, date and place 29c. License number	ce, and due to the	e cause(s) and manner a	s stated.
	878		▶ M. 11 (/////)	D41270		2/22/20)	
	Na		30. Name and address of person who completed cause of death (Item 23a) (Ty)	pe, Print)		7-720	_
	5		Michael Costello, MD 1564 Opossumto		D 21702		
	Stat		31. Date filed (Month, Day, Year)				
	Registra	r	FEB 2 8 2012 Janua S. A	barles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Susan Nelson Dixon 2054 2012 Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Year) 1968 New Jersey Director 148-54-2415 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 USA 300 North Union Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than " Radio life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Executive Communications traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 2 be 1 Patricia De Berry Louis Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2613 Cullum Road Bel Air, MD 21015 Ingo Rucker / step-father other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ŏ Department of Important: If it cemetery, crematory or other place) ō 1 Durial 2 X Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Final Journey Crematory 2/28/12 21. Signature of Fineral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service, P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE CROHN'S Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Directo for selection considerate of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADRENAL INSUFFICIENCY Hospital or Attending Physician: The law requires 1 ☐ Yes 2 To No 3 ☐ Probably 4 ☐ Unknown CHRONIC KLONEY DISPASE, STAGETY Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Division of 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Andrea Novalionsla D08096 PEBRUARY 26, 2/0/2

DHMH 17 Rev 7/2009

Registrar

barker

MD

32. Registrar's Signature

- FULFORD AVE BELMIR, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSFI

FEB 2 8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#46, perPHYS#10b, perFH, G924, 2/28/2012, WS
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:45 A M DWARD PAYL DENHAM ESTUALY Medical 4a. Facility Name (if not institution, give street and number, County of Death
Washington **Examiner** 4b. City, Town, or Location of Death HAGENSTOWN NORWAY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year Country Director 75 014-28 -0423 MASSACTUSESS Usual Residence of Decedent 23a or 28a-f show ust be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Washington 1 X Yes 2 □ No MD HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral "natural", or items 23: 21740 218 NORWAY U. S. A Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No If Yes, Give Specify: 3 Divorced 4 Divorced Completed WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) STEEL FALTORY MORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FREDERICK DENHAM HELEN GAENANI 19a. Informant's Name/Relationship (Type, Print) LIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 -0415E DENHAM HAGERSTOWN item 2 H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ARDENT CRUMATION FEB. 24.2013 HANOUER, MO. 21. Signature of Furieral Sep 22. Name and Address of Facility MARZULLO FUNERAL CHAPEC e Licenze JOSEPH L. CAMBY 20 6009 HARFORD ROAD BALTIMORE 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for it or heart failure. List only ne cause on each line. m00078 23a. P.v Approximate Interval Between Onset and Death te Cause (Final Physician/ Prostate se or condition Medical Examiner resulting in death) Due to (dr as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Pregnant at time of death ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown P.O. ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}}\) Nursing Home 5 \(\frac{1}{2}\) Residence 6 \(\text{\text{\text{\text{Other}}}}\) Other (Specify) lospital: 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge dietri scrumed at the time date and place, and due to the cause(s) and mainer as state 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 PENNSYLLAMIA ALE HAGEKSTOWN MD HATLEBUR STEPHAN *ユロ42* 31. Date filed (Month, Day, Year) Règistrar's Sign State FEB 2 8 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 2012 Medical **Examiner** 4c. County of Death atonsville 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 F Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Town or Location 10d. Inside City Limits Director Baltimore atonsville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? δ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ₩Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) College (1-4 or 5+) Norker Be State, Zip Code) 21228 Neta Mae 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State

Brooklyn md 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-2012 21. Sign at tre of Funeral Service License Cracili Greene Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCE METASTATIC disease or condition 4 months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in resolute Examiner this to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) Year ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl Hospital or Attending Physician: The law performed 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 🗆 Pending work? 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOKE 31. Date filed (Month, Day, Year FEB 2 8 2012 State Registrar

2-24-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 **P** M 4:15 February John Joseph Dimsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glenn Dale Prince George's 12113 Augusta Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral (Month, Day, Year) Days Hours Min. 578-14-5484 89 Director 1 X M 2 □ F 09/06/1922 Washington D.C. Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location the Maryland Director 1 Yes 2 X No Maryland Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12113 Augusta Drive 20769 U. S. A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: White Year or Dates. 1944-46 Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. U. S. Department of Elementary/Secondary (0-12) 12 College (1-4 or 5+) Machinist/Analyst the Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ William Ralph pe Dimsev Kathryn Cecilia permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Barnard/Daughter 12113 Augusta Drive, Glenn Dale, Maryland 20769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/27/2012 Huntt Crematory Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, the C. Kan 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain Tumor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death been signed by the a should be detached Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?

1 Yes 2 X No has this certificate 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🛚 No Hospital: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After iniurv 1 XNatural 5 Pending work?
1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours af er dect Funeral Director filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the P only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23743 2/27/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, 7525 Greenway Center Drive, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) Registrar's Signatur State FEB 28

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		4	State	aryland / [artment of H <i>tificate of D</i>			2.0	12	05829
			1. Decedent's Name (First, Middle, Last)		001	incate of D	Catri	2. Date of De			3. Time of Death
	Physicia Medic		IRIS ALEASE DA	VIS				Februa	ry 19 20	0 1 2 ear	7:45a ^M
	Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or			4c. County	of Death	CO
Sec.	Funeral		2108 WILLIAMS DRIVE 5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birt	hday)	If Under 1 Year	DE GRAC	8. Date of Bir	th	g. Birthp	lace (State or Foreign
	Director		227-44-1475 1□M2፟MF	81	Yrs.	Months Days	Hours Min	(1 1930	VIR	GINIA
	nd ihow at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Loc	cation				1	0d. Inside City Limits
	Maryla 18a-f s tiffied	rect	MARYLAND HARFORD CO			HA	VRE DE	GRACE			1 ☐ Yes 2 🔀 No
~	h the l	al Di	10e. Street and Number	-		10f. Zip Code			10g. Citizen of \		try?
	ath wit	Funeral Director	2108 WILLIAMS DRIVE 11. Marital Status 12. Was Decedent	Ever in ITS	13 V	Vas Decedent of His	21078 spanic Origin? (S	pecify Yes or No-	U.S	· A ·	an Indian
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married		11	Yes, specify Cubar	n, Mexican, Puer	to Rican, etc.)	Blac	BLAC	etc.
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ylar	should be file and Mental I 7 is marked c raumatic eve	입	WILLIAM L. VENEY					VENEY			
Mar	2 shouth and the and the and traum	- 9	19a. Informant's Name/Relationship (Type, Print) Victoria M. Johnson/Daugh	7.0		ng Address (Street a					
re,	1 and if Heal item 3		20a. Method of Disposition	20b. Place o	f Dispo	sition (Name of		Date Date	20c. Location		
imo	Page ment o ant: If ury or		1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	7		BAPTIST		5-2012	JOPPA,	MARY	LAND
Baltimore, Maryland 21215-0036	permit. Departi Import any inji	b	21. Signature of Fundal Service Constitution (Service)		22 W 3	Name and Addres TLLIAM C 21 S PHII	s of Facility BROWN C LA. BLVD	OMM FUNE	RAL HOM	E-HAR , 210	FORD, P.A.
	Medical Examiner	<u>.</u> .	Sequentially list conditions, b.	a consequence	of):	MUC	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ls, P.O.	uires that th signed by ld be deta	þ	Part II. Other significant conditions contributing to death	but not resulting	in the u	ınderlying cause giv	en in Part I.	23e. Did t	/		ne cause of death? pably 4 🗆 Unknown
Division of Vital Records,	sician: The law requires that the certificate has been signed by tifirector, page 2 should be detach	Completed							psy ormed?		psy findings available mpletion of cause of
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n of V	ding Phy h. After this funeral c	cate: To	1 Yes 2 No 1 Inpa 27. Manner eath		utpatier Time of injury	28c. Injury	4 ∐ Nursing ⁄at	Home 5 A Resi	dence 6 L Oth)
Divisio	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, fa tc. (Specify)	arm, str	eet, factory, office		28f. Location (City or Tou	Street and Numb vn, State)	er or Rural	Route Number,
_	Hospit 24 hour Funera etely fills	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of	examination and/	or inves	tigation, in my opinio	on, death occurred	d at the time, date	and place, and du	ie to the cai	use(s) and manner stated.
_	To the within To the comple	Σ	only one) 3 Certifying Nurse Practitioner: To to 29b. Signature and title of certifier	me best of my kno	wieage	29c. License		227	29d. Date signe		
)		30, Name and address of person with completed cause of	death (Item 23a)	(Type, F	Print) Ph	1000	601	v R.I		MD 21014
	Sta	te	H VOYAL UL 5 31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	Pf	ver GU	sape	uce			111/201
	Registr	ar	FEB 2 8 2012 /2	B. A.	ares.						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05830 State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 9:09 A^{M} Endres <u>February</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 2300 Edwards Lane Bel Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Hours **Director** 219-32-8508 1 🕅 M 2 □ F 74 June 17,1937 Maryland Usual Residence of Deceder 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director Bel Air 1 Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 238 Funeral 21015 United States Edwards Lane 2300 items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1. Marital Status Black, White, etc. 0 Yes 2 No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Specify: "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with... **al Hygiene. **ar than "r (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Bob Ward Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Endres Marv Alsruhe Carl traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a 2300 Edwards Lane, Bel Air, Maryland 21015 Janice Endres / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc | 02/28/2012 | Baltimore, Maryland 22. Name and Address of Facilit@remation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CANCER UNG Physician mont 1+3 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) death certificate be executed -tran and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1-Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed 1 🗌 Yes 2 🔲 No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00058475 PHTSEUT KN FIFDRUART 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TP 510 UPPIN CHUSA PRAKTE ORIVE BECAZEND 21614 MUVAT N ZAUG 31. Date filed (Month, Day, Year) 3 Registrar's Signa

Registrar DHMH 17 Rev 06-2011

State

FEB 2 8 2012

			Pleas	se Type or Pr							_	•
			For State	State of M	laryland /				Mental Hy	ygiene	2015	0583
			Registrar			Cert	ificate of E	Death		Reg. No	2012	. 0303
	Physicia Medic		1. Decedent's Name (First, Middle, James	Last)			Ellio	tt	2. Date of D Month FEB	eath Da 2.3		3. Time of Death 0325 M
-	Examin		4a. Facility Name (if not institution, str. AGNES		-AL		4b. City, Town, or BAL 7	Location of Deat		4c.	. County of Deat	h
	Funeral Director		214-44-0427	6. Sex 7. Ag 1 X M 2 □ F	ge (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B (Month, D	ay, Year)		thplace (State or Foreigr untry) MD
	nd now	Ē	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loca	tion					10d. Inside City Limits
	arylar a-f sk fied a	Director	MD NA									1 🛱 Yes 2 🗆 No
	he Ma or 28	ğ	10e. Street and Number	-	_ Bo	altin	10f. Zip Code			10a, Cit	tizen of What Co	
	with t	Funeral	2521 Reisters	town Road			2	1217			U.S.A	·
	death items	핊	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa	as Decedent of Hi res, specify Cuba	spanic Origin? (S	pecify Yes or No)-	14. Race - Ame	
9000	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 ☐ Marrie	If Yes, Give Year or Dates.	l No		Yes 2x No		o riiouri, ete.,		Black, White Specify: B	lack
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≥, ≤	and 2 s Health tern 27 other tra		Shawn Elliott	-Daughter				rstown	Road,	Bal	timore	, Md 2121
altimore, Maryland 21215-0036	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1 Page Burial 2 Cremation 3 4 Donation 5 Donation 5	3 ☐ Removal from State	ceme	tery, crema	tion (Name of tory or other place prial P	· •	Date 2/2012	1	ocation - City or	
Balt	permit. Page 1 Department of Important: If i any Injury or once.		21. Signature of Funer Service Lic	u A		Mar	Name and Address Ch F/H	west				52
			23a. Part 1. Enter the disease, or c shock, or leart failure. List on	omplications that cause	d the death. Do							Approximate Interval Between
	Pnysician/	10	Immediate Cause (Final disease or condition	,		TH	ROMB	OEMB	OLIS	M		Onset and Death
-	Medical Examiner		resulting in death)		a consequence		D. 45	0	20	n = 0		15 MONTH
П		-	Sequentially list conditions,		a consequence		BLAD	DDEK	CANC	EK		13 1900 117
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequence	e oi).						
	executed an and rial-transi	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence	e of):						
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Box 68760	e death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Year
P.O.	requires that the de been signed by the should be detached	y Pr	Part II. Other significant condition	s contributing to death l	out not resulting	g in the und	derlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
S,	n sign	q pe	HYPER TE	NSION					1 🗆	Yes 2	X No 3 □ Pi	obably 4 🗆 Unknowr
corc	has beer	Completed by	DIABETE	S MELLI	TUS					opsy	24b. Were autoprior to death?	topsy findings available completion of cause of
m m	ician: The la certificate ha rector, page		25. Was case referred to medical						1 🗆 Yes	formed?		2 🗆 No
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of/	g Phy er this eral c		27. Manner of Death	28a. Date of inju	ıry 28b	. Time of	28c. Injury	at	28d. Describe		Other (Spec y occurred	<u> </u>
on	endin sath. or: Aft he fur	fical	1 Natural 5 Pending 2 Accident Investiga	ation	ly, rear)	injury	M 1 🗆	Yes 2 No				
Division of Vital Records,	tal or Attorns after de al Directored in by t	l Certificate:	3 Suicide 6 Could not 4 Homicide determin			farm, stree	t, factory, office			(Street and wn, State)		al Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examination and	l/or investig	ation, in my opinio	n, death occurred	at the time, date	and place,	, and due to the o	ause(s) and manner state
	Vithi Con	- I	29b. Signature and title of certifier	4	14 7		29c. License		,		te signed (Month	
				,	M.D.		DO	06774	ł	Fe	bruary	27th, 2012

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALID BARBOUR, 312 N MLKJr Blvd, 2nd FL, BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

FEB 2 8 2012 Sensor S. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. February 24. 20T2 00:30A Jean Marie Ernst Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hosptial Center Westminster Carroll 5. Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth **Funeral** May 14, 1937 1 🗆 M 2 💢 F Months Hours 74 Director 213-36-4445 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 2381 Mayberry Road 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 'natural", or à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 😾 Widowed 4 🗆 Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 | th and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Carrier Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Dobbin Alma Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Mrs. Lisa COrbin (Daughter) 2381 Mayberry Road, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 2/27/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 Haids 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed ng physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery t 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No After this certificate 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending work To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident
Suicide 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRACIE 1. RUBERA D.O. 689-C. P

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Records,

Division of Vital

32. Regierar's Signature

poole Rd. Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 298 Februar 10:45 osen 201 Medical 4c. County of Death give street and number) 4b. City, Town, or Location of Death 4a. Facility Name (if not institution **Examiner** N/A timor zabeth sine 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth **Funeral** Country) Maryland (Month, Pay,) 1 🕅 M 2 □ F Months Days Hours Min 82 Yrs. 220-24-0717 Mar. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Baltimore Maryland Baltimore City 1 Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 21229 United States 119 South Culver Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. X Yes 2 No 1951 Yes, Give 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. White 3 Widowed 4 Divorced **-1953** Completed Year or Dates. 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Hughes Fitzgerald John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 9 McLendon Ct., Windsor Mill, Maryland 21244 William Scheele / Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/02/2012 Baltimore, Maryland New Cathedral Cem. 22. Name and Address of Facility MacNabo Funeral Home, P.A. Signature of Funeral Service Licensee Thomas Gregor 301 Frederick Rd., Catonsville, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Onset and Death Immediate Cause (Final C Physician/ disease or condition resulting in death) Medical **Examiner** rona Esqueritially list conditions, Examine if any, leading to immediate cause. Enter Underlying be attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed a Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral directions 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending death. Accident Investigation within 24 hours after death

To the Funeral Director: ompleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my entire Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar WWD

31. Date filed (Month.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

orothy Lee Fike			ate of Maryla	and / Dep	partment o				ream	20	12 05	83!
		1- For State Registrar 1. Decedent's Name (First, Midd	In Land)	C	ertificate c	f Death		2. Date of	Reg. N	0.	10 T (6	
Physicia ledical Examin		Dorothy Lee F:	ike					Month Februa	Day ary 24, 2		3. Time of De 1705 hr	
		4a. Facility Name (if not institution Franklin Sqaure Hosp		umber)		4b. City, Town, o	or Location of E	Death	ľ	4c. County of Baltimore		
Funeral	╗	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Ye			of Birth (MI		9. Birthplace (State	or
Director		219-50-3043	1 M 2 XF		61 Yr	Months Da	ys Hours	Min. Nov	30,	1950	Country) Mary	'land
any	H	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loca	tion					10d. Inside C	ity Limits
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th the Maryland 23a or 28a-f sho notified at once		3409 Dahlia La					.220			USA		
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fre de		3 Widowed 4 XDiv	1 Yes rorced If Yes, Give Yes	2 LX No ar		Yes 2 X N	o specify:			Specify: W	hite	
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e, MD 1 and 2 sho Health and item 27 is	-	Monique Ann Fo	oltz, Sist			Dahlia sition (Name of co		Middle			yland 212 ity or Town, State	:20
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Box e death o the atten ed for us	Physici	1 Yes 2 No 9 V Uni		own	3 0	ther (Specify)						
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Division tal or Attendin is after death.	icat Icat	2 Accident Inves	stigation IU Z-	-24-12 e of Injury - At	fd 4:0	et, factory, office		28f. Location	n (Street	and Number	or Rural Route Num	ber, City
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1 Open	ŀ	30. Name and address of person		-	·							
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Sta	_	31. Date filed (Month, Day, Year)	2012 3	gional o Olyila	1 Louis	led						

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 's Name (First, Middle, Last) 2. Date of Death FREDERICKS Month Year Physician/ DAROTHY 1.30 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Augsburg Lutheran Home Villanova 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month 1 □ M 2 🗓 F Months Hours Min. 93 Connecticut 048-01-8440 **Director** Jan Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Middle River Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 12733 Cunninghill Cove Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha traumatic event, the Fairfield University Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isaac Tuck Clara Grainger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12733 Cunninghill Cove Road, Baltimore, Maryland21220 Alan D, Fredericks : Son 20a. Method of Disposition
1 □ Burial 2 🏿 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Ardent Cremation, Inc. 2-28-12 4 Donation 5 Other (Specify) Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses 6009 Harford Road, Baltimore, Maryland 21214 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Same tight list couldth. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of death? has performed 24 No Yes 20 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after death Funeral Director: A filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 7 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

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1 ASNEEM
31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		135-07-78		1 🗆 M 2		91	Yrs.	Months		Hours	Min.	(Month, Di	ay, Year)		Cou	nsylvania
nd now at	_	Usual Residence of 10a. State	of Decedent 10b. County			10c. Cit	y, Town or Lo	cation	<u> </u>			ouie i	J, 1.	520	1011	10d. Inside City Limits
farylar Ba-f sl tified	ectc	Penn.	York	County	7		,	1	York	Κ						1 ☐ Yes 2X No
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th with ms 23 must	Funeral Director	330 Rita	Road	10.14	- Danadası	Francia (II)	2 140		7402		-0/0-0	aifu Van au Na		ted S		
or ite	by Ft	11. Marital Status1 Never Marri	ied 2 🗆 Mari	Arı	as Decedent med Forces? Yes 2X			If Yes, sp	ecify Cuba	n, Mexican,	n? (Spe Puerto	cify Yes or No- Rican, etc.)			e - Ameri ck, White	ican Indian, , etc.
urs aft :ural", al Exal		3 🛚 Widowed	4 Divorced		es, Give ar or Dates.			1 🗌 Yes	2X No	Specify:				Specify	Whit	:e
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Janet Far										ennsy ${f l}$				Code)
pe 1 an t of He If iten or oth		20a. Method of Disp		3 Remov	al from State		Place of Dispo emetery, crea		-41	e)		Date				Town, State
irt. Pag irtmen ortant: njury		4 Donation 21. Signature of Fur	5 Other (S	Specify)		Ev										, Maryland
Depart Impo		La Signature of Full	AN A	Len	~		E (ans News	Funer ort I	ral Ch Drive.	ape. Fo	l & Cre rest Hi	mat:	ion S Mary	Servi Zland	ices-BelAir 1 21050
		23a. Part 1. Enter the shock, or hear	he disease, or rt failure. List o	nly one caus	e on each lin	0	h. Do not ent	er the mo	de of dying	g, such as ca	ardiac o	r respiratory a	rrest,			Approximate Interval Between
Physician/		Immediate Cause (_ a. A	thero	sule	rotic	, C	ARd	iOVA	-5 CI	LLAR	dis	seA5	ε	Onset and Death
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requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medical	1 Yes 2 D	No		□ Pregnant□ Unknown	at time of o	death 5	Other (specify)					IVIC	nth	Day Year
that the ned by e detay		Part II. Other signif	icant condition	ns contributi	ng to death	out not res	sulting in the I	underlying	g cause giv	en in Part I.		23e. Did	tobacco	use cont	ribute to t	the cause of death?
quires en sig ould b	ted											1 🗆	Yes 2	2 No	3 Pro	obably 4 🕅 Unknown
law re has be je 2 sh	Completed by					<u>.</u>						24a. Was				opsy findings available ompletion of cause of
sician: The law is certificate has build director, page 2 s		25. Was case referre	ed to medical						26 🖫	ace of Death	(Chack	1 \(\text{Yes}	2 🕅 1			2 🖫 No
ysician: is certific director,	To Be	examiner? 1 Yes 2 \$\int\$	☑ No	Hospita		ient 2 🗌	ER/Outpatie	nt 3 🗆 [Othe		· -		idence	6 X Othe	er (Specif	s) Assisted Living
ding Phys h. After this funeral di		27. Manner of Death 1 Matural	n 5 ☐ Pendin		a. Date of inj (Month, Da		28b. Time o injury		28c. Injury work	/ at ?		28d. Describe				/
after death Director: A	Certificate:	2 Accident 3 Suicide	Investig 6 Could	not be	. Place of Ini	urv - At ho	ome, farm, str	M eet. facto		Yes 2 N	\rightarrow	28f Location (Street a	nd Numbi	er or Rum	al Route Number,
tal or /		4 Homicide	determ	ined	building, et			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,			City or To			or or reare	a react running,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical		Certifying Medical E													ited. ause(s) and manner stated.
o the vithin 2 or the comple	ž	only one) 3 29b. Signature and	Certifying title of certifier		titioner: To th	ne best of r	ny knowledge		curred at the		and pla	ice, and due to				stated. Day, Year)
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2 m		30. Name and addre	ess of person	who complete			23a) (Type, I	Print)				A 2	,	4	//	Nd 21014
State	e	MAR 31. Date filed (Monti		100	V -	JORT ar's Signa		VE	NUC	, B	じ ー	AIR		MAR	YLA	NO OCIDIY
Registra			B 2 9 2	2012	Denma	الم ر	. pa	Kal	-							

DHMH 17 Rev 06-2011

		Plea	ase Type or Pri State of M								9		05027
		State Registrar	t A		Cer	tificate of I	Death			Reg. No	201	2	05837
Physicia Medic		1. Decedent's Name (First, Middle CAROL	PATR	ICE		FRANKL]			2. Date of De Month FEBRUA	RY 2	2 2012		3. Time of Death 6:28 A ^M
Examin	er	4a. Facility Name (if not institution HOLY CROSS	,			4b. City, Town, o					: County of I		
Funeral		5. Social Security Number	100	e (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da	th ny, Year)	9	. Birthpla Country	ace (State or Foreign
Director		147-46-0804 Usual Residence of Decedent	1 □ M 2 □ X F 6		Yrs.				DEC. 2	5 19	51	NEW	JERSEY
ıryland a-f sho ied at	ctor	10a. State 10b. County		,	Town or Loc							100	d. Inside City Limits
the Ma or 28a e notifi	Dire	MD PRINC 10e. Street and Number	E GEORGE'S	1 01	PER M	ARLBORO 10f. Zip Code				10g. Ci	tizen of Wha	t Countr	
th with ms 23a	Funeral Director		TON DRIVE			20774				USA			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Married 2 ☐ Mar3 ☐ Widowed 4 ☒ Divorced	If You Give		lf lf	Vas Decedent of F Yes, specify Cuba	an, Mexic	an, Puerto	ecity Yes or No- Rican, etc.)		14. Race - A Black, \ Specify:	White, etc	С.
72 hour	Completed		nt's Education est grade completed)		(Give F	ent's Usual Occup and of work done	during mo	ost of work	ing	16b. K	Kind of Busin	ess/Indu	stry
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e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, I WARREN GLASCOE	Last)						e (First, Middle,		Sumame)		
nould b nd Mei s mark umatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street		ENEVA	SEWEL		r Town, State	e, <i>Zip</i> Co	de)
nd 2 sh ealth a m 27 is ner trai		IMANI FRANKLIN	/DAUGHTER		12302	CHESTER				MAR	L.BORO	MAR'	YLAND 2077
age 1 a ant of H it: If ite y or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (8)		ce	metery, crem	sition (Name of natory or other pla CION CEMI			Date / 2012		ocation - Cit		
permit. Pa Departme Importar any injur		21. Signature of Funeral Service L	<u>· · · · · · · · · · · · · · · · · · · </u>	KES							NTON,		HOME, INC.
89789		23a. Part 1. Enter the disease, or	T Callow	al was ald not b		7474 LANI					LE,MAI		
Physician/ Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each line	RATOR	Y ARRI		ig, sucii e	as cardiac c	- respiratory ai	Test,		- 1	Approximate nterval Between Onset and Death
Examiner		Sequentially list conditions,	DIABE		ince oi).								
ed Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as ASYST		ence of):								
G F E		that initiated events resulting in death) Last	cDue to (or as		ence of):							+	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су				23d. Date o	_	/ ay Year
that the	y Ph	Part II. Other significant condition	_	out not resu	Iting in the u	nderlying cause gi	iven in Pa	rt I.	23e. Did t	obacco	use contribu	te to the	cause of death?
equires een sign ould be	ted b	GRAVES DISEA	SE					-	1 🗆	Yes 2	□ No 3[Proba	bly 4 X Unknown
: The law re cate has be r, page 2 sh	Completed								24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?	prio dea:	r to com	y findings available pletion of cause of
/sician s certifi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 K 1 F	R/Outpatien	041	er.	eath (Check	me 5 🗆 Resi	dence f	S Cher (9	Specify)	
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Attending death ctor: A	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be	ury - At hon	ne, farm, stre		Yes 2	∐ No	28f. Location (Street an	nd Number o	r Rural R	oute Number,
ital or / irs after al Dire			building, etc	c. (Specify)					City or Tov	vn, State	e) 		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 L Medical E	p Physician: To the best of Examiner: On the basis of e p Nurse Practitioner: To th	xamination	and/or invest	igation, in my opini	on, death	occurred at	the time, date a	and place	e, and due to	the cause	e(s) and manner stated.
vith To th		29b. Signature and title of certified	16 &	1/		29c. Licens		r		29d. Da	ite signed (N	onth, Da	ly, Year)
Jan		30. Name and address of person				rint)	3435		ID 67===	d	ay c	- I	
Stat	e	AARON KENIGSB					1307	SILVE	K SPRI	NG,M	AKYLAI	ND 20	J902
Registra		FEB 2 8 2012	Denver A	1. 4	and	·							

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 25 2012 Physician/ 1:00 A M HUMU HAWA FOFANAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) FREETOWN 7. Age (In yrs. last birthday) **Funeral** Days Director 216-19-2313 1 M 2 XF 84 SIERRA-LEONE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director be notified 28a-f 1 √ Yes 2 □ No PRINCE GEORGE'S FORT WASHINGTON MD 5 10e. Street and Numbe 10g. Citizen of What Country? 23a USA 13511 PENDLETON STREET 20744 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i Completed by 2 X No 1 Never Married 2 Married 1 ☐ Yes 1 ☐ Yes 2 X No Specify. BLACK Specify Year or Dates other than "nature ent, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ENTREPRENEUR PRIVATE 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည marked ABDULAH FOFANAH ISATU SILLAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>.s</u> 13511 PENDLETON STREET FT. WASHINGTON, MARYLAND 27 JONAS H. FYNCH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ₽ NATIONAL CEMETERY 2/27/2012 4 Donation 5 Other (Specify) LAUREL, MARYLAND J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service License 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ BACTERIMIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) STROKE use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 No prior to completion of cause of death? page 2 has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Hospital Other: 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Hospital 24 hours Medical 29a. Certifier 1 ሺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D65305 FEBRUARY 26, 2012 Ggn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

FEB 2 8 201

Baltimcre, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

NABILA KHAN MD 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20785

2-01607	Please Type or Print in Black Indelible			
Edith Jane Fisher	State of Maryland / Department 1- For State Registrar Certificate		ygiene Reg. No. 201	2 0583
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	17	2. Date of Death Month Day Year February 23, 2012	3. Time of Death
	Facility Name (if not institution, give street and number) Dove House	4b. City, Town, or Location of Death Westminster	4c, County of Dea Carroll	th
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-22-7928 1 M 2 K F 98	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. B Fore Feb. 27, 1913	irthplace (State or ign New York ountry)
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
ith the Maryland 23a or 23a-f show notified at once.	MD Baltimore R 10e. Street and Number	eisterstown 10f. Zip Code	10g. Citizen of What Co	1 Yes 2 X No untry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she satic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? I Yes 2 No	21136 Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,
2 hours after "natural", I Examiner eted by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	Yes 2 No specify: lent's Usual Occupation (Give kind of w most of working life, DO NOT use retir	ork done 16b. Kind of Business	nite /Industry
21215-0036 uld be filed within 72 hours aft Mental Hygiene. marked other than "matural" c event, the Medical Examine To Be Completed by	9 As 17. Father's Name (First, Middle, Last)	sembly Line Worker 18.Mother's Name	r Bendix (First, Middle, Maiden Surname)	
ID 21215-00; should be filed with and whental Hygiene and Mental Hygiene in marked other Instite event, the Mental Hygiene To Be Com	John Allender 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Edith ing Address (Street and Number or F	n Jane 0 * De11 Rural Route Number, City or Town, Stat	e, Zip Code)
re, M s 1 and 2 of Health If item 2		osition (Name of cemetery,	Date 20c. Location - City o	
Baltimore, permit Pages I as Department of He Important: If ite	21. Signature of Funeral Service Licensee 22		11824 Reisterstown	Road
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		Reisterstown, MI respiratory arrest, shock, or heart	21136 Approximate Interval Between Onset and Death
<u> E</u> xaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Immediate Cause (Final disease or condition so it right femurified but to (or as a consequence of): Due to (or as a consequence of):	idio.		
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			3
executed an and al - transit	d. UNPENDED M AMENDED #3,per me,g925 9perFH,G925,3	5,3-8-12 sm		<u> </u>
x 68 h certi tendin use as	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnal Other (Specify)	23d. Date of delive Month	Ty Day Year
ires that the deati signed by the att 1 be detached for d by Physi	Part II. Other significant conditions contributing to death but not resulting in the Congestive Heart Failure, Severe Aortic Stenosis	aunderlying cause given in Part I.	23e. Did tobacco use contribute to	-
Division of Vital Records, P.O. to the Bospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detaced after the death of the funeral completely filled in by the funeral director, page 2 should be detaced after the funeral completed by F.	25. Mar ages referred to modified	26 Diago of Double (Chaple	autopsy prior to death? 1 Yes 2 ✓ No 1 Y	utopsy findings available completion of cause of es 2 No
f Vital Physician r this certi ral director	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check of De	g Home 5 Residence 6 🗸 Othe	er: Scene
sion of ttending Pl death. ctor. After y the funeral	27. Manner of Death 1	1 Yes 2 ✔ No	28d. Describe how injury occurred Subject fell	
Division o to the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune edical Certification:	3 Suicide 6 Could not be determined (Specify) Nursing Home 29a. Certifier		28f. Location (Street and Number or R or Town, State) Carroll Lutheran Village, Westmir	•
To the Ho within 24 I To the Fu completely	29a. Certifier 1 Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Signature and title of certifier			he cause(s)
D D M	mille	O.C.M.E.	February 25, 20	
(*)	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Ba	altimore Street, Baltimore, MD	21223	
State Registrar	31. Detection (Month, Day Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:38 A M Wallace Frantz 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Roseda Samare ranklin Hospita If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Director 1 🗆 M 2 💢 F 218-03-7103 Jan. 25, 1918 Maryland 94 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 💢 No Maryland Baltimore Nottingham r items 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Frantz Novella Baltimore, Maryland 21215-0036 5 Redfield Ct. 21236 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò ģ 1 Never Married 2 Married 1 Yes 2 X No Specify. Yes. Give 3 X Widowed 4 Divorced White Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th. Grade Secretary Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome Bonaparte Hurley Emma Snow Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Redfield Ct., Gwenda Yost/Daughter Baltimore t: If item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Parkwood Cemetery 02/27/2012 Baltimore 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Road Baltimore Signature of Funeral Service Licensee 21236 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown After this certificate has been signed by interest director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by te 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 VIV completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita! ပ 1 Inpatient 2 (ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D53462 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and mare Drive, Baltimore, MD 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a Per PHY G924 2/28/2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D24 Physician/ 2012 Kathleen McDonald **Fuss** February 12:13 A M Medical 4c. County of DeathQueen Anne's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 105 Ryan Court Chestertown -Kent Social Security Numbe . Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 \square M 2 \square F Months Days Hours Month P22/1947 County Maryland 218-52-4134 64 Director Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗆 Yes 2 🔀 No MD Oueen Anne's Chestertown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Ryan Court 21620 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Teacher 12 5+ Education Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William F. McDonald III Jean A. Smith and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald K. Fuss / Husband 105 Ryan Court, Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/25/2012 Beltsville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mont Year Pregnant at time of death Month Day be detached the g 🗌 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? To Be Completed by Prior Adri Value Replacement Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown morthage sp Aneursm 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes filled in by the funeral director, 25. Was case referred to Place of Death (Check only one) examiner Other: 1 Inpatient 2 I ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending injury 5 Pending work? Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1205

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sample Shady Grove Adventist Hospital Shady Grove Adventist	Intgomery Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No Country? USA Interican Indian, hite, etc. White ss/Industry Law Zip Code)
Physician/ Medical Examiner Charles Manuel Fernandez Charles Manuel Fernandez 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital Shady Grove Adventist Hospital Funeral Director Charles Manuel Fernandez 4b. City, Town, or Location of Death Rockville Rockville Social Security Number 055-50-3075 1 Molth Park If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number O55-50-3075 1 Molth Park Year O3/30/1936	eath ntgomery Birthplace (State or Foreign Country) Jod. Inside City Limits 1 X Yes 2 No Country? JSA merican Indian, hite, etc. White ss/Industry Law Zip Code)
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Shady Grove Adventist Hospital Box Adventist Hospital Social Security Number 0.55-50-3075 1 M 2 F 55 Yrs. Age (in yrs. last birthday) 1 Months Days Hours Min. Months Min. Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Min. Months Months Months Months Months Min. Months Month	Intgomery Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No Country? USA Inerican Indian, hite, etc. White ss/Industry Law Zip Code)
Funeral Director 5. Social Security Number 055-50-3075 1 M 2 D F 5. Social Se	Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 X Yes 2 No Country? USA merican Indian, hite, etc. White ss/Industry Law Zip Code)
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3 Wildowed 4 Divorced For Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	ss/Industry Law Zip Code)
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 5+ Attorney 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	Law Zip Code)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) Strong Attorney 18. Mother's Name (First, Middle, Maiden Surname)	Zip Code)
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Celestino Fernandez Celida De La Cruz	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 17805 Cricket Hill Drive, Germantown, MD 20874	
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City	
1 □ Burial 2 Cremation 3 □ Removal from State cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2/28/2012 Belts	ville, MD
21. Signature of Funeral Service Licensee Dorota Marshall Dorote Licensee 22. Name and Address of Facility Maryland Cremation Services, PO BOX 1413 Balti	more, MD 21203
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician/ Immediate Cause (Final disease or condition respiratory failure	Onset and Death
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FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of in the past 12 months? 23d. Date of in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month	delivery Day Year
Up to the past 12 months? 1 Pest II of the past 12 months 12 mon	Day real
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 1 Yes 2 No 3 2 Yes 3 2 Yes 3	
The state of the s	autopsy findings available
1 Yes 2 No 3 an emia an emia 24a. Was an autopsy performed? 1 Yes 2 No 1 1 Yes 2 No 3 24b. Were priori death 1 Yes 2 No 1 1 Yes 2 No 3 24b. Were priori death 1 Yes 2 No 3 24c. Was an autopsy performed? 1 Yes 2 No 3 24d. Was an autopsy performed? 1 Yes 2 No 3 24d. Was an autopsy performed? 1 Yes 2 No 3 24d. Was an autopsy performed? 1 Yes 2 No 3 24d. Was an autopsy performed? 1 Yes 2 No 3 24d. Was an autopsy performed?	o completion of cause of
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Hospital: 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp	ecify)
28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred injury 28d. Describe how injury occurred work? Accident Investigation	
27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of injury work? 1 Pending 28c. Injury at work? 1 Pending 28b. Time of injury 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of injury at work? 1 Pending 28b. Time of injury at work? 1 Pending 28c. Injury at work? 1 Pending 28c. Injury at work? 28b. Describe how injury occurred	Rural Route Number,
b the contract of the contract	
FEMALE: 23b. Was decedent pregnant 1	e cause(s) and manner stated
	nth, Day, Year)
prometured p.o. H72163 February	25,2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammod Mehmood, 00 9901 Medical center Drive, Pochville, Ma	mlorel 20850
State 31. Date filed (Month, Day, Year) 32. Systrar's Signature Registrar FEB 2 8 2012 August Augus	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A M Billie Jean Walker Gray February 2012 2:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ritchey House Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Hours Min (Month, Day, Year) **Director** 577-46-1828 1 🗆 M 2 🗓 F Yrs. 77 11-26-34 North Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fairfax VA Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6604 Boulevard View Apt. 22307 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester C. Walker Flora Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Niece) June Foster 603 Westham Woods Dr., Richmond, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Wilkie's Grove Bapt Ch Cem 02/28/2012 Hickory, NC Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Fuenral Service 5517 Vine St. Alexandria, VA 22310 MO1284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the at d be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatura and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6114 CA 31. Date filed (Month, Day, Year) FEB 2 8 201 State Registrar

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		For		S	State of	Marylan					and N	nental Hy	gien	е			
	_	State Registrar					Ce	rtificat	e of E	Death		,	Reg. N	10.20	12	05844	
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Examin		4a. Facility Name (if Manor				er)		4b. City,		Location omac	of Death		4	lc. County Mo	of Death	mery	
Funeral Director		5. Social Security No. 214-52-		6. Sex	2XX _F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 6	ay, Year)		Coun	place (State or Foreign htry) V York	
and show dat	tor	Usual Residence of 10a. State	of Decedent 10b. County			10c. Cit	y, Town or Lo	cation				5000	,			0d. Inside City Limits	_
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Marr 3 [X]Widowed		ried	Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	X No		Was Deced If Yes, spec 1 Yes	ify Cuba	n, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)			k, White,	can Indian, etc. White	
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Page 1 arment of Hisant: If itel		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	X Cremation		noval from St	tate C	Place of Dispo emetery, cre esapea	matory or c	ther plac	ory		Date 28/2012		Location - Belts			
permit. Depart Import any inj		21. Signature of Fu	iera Se vice L	icensee								Cremat: ver Sp				20910	
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? X No		1 Live Bi	me of pregna rth 2 ☐ Feta nt at time of c	al death 3	Cotopic Other (sp		÷у				23d. Dat	te of deliv nth	ery Day Year	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	only one) 3	Medical E Certifying	xaminer: (Nurse Pr	On the basis	of examination	n and/or inves	stigation, in	my opinic	on, death o	ccurred a	nd due to the c t the time, date ace, and due to	and plac	ce, and due	e to the ca	use(s) and manner stated	d.
N M with		29b. Signature and	jitle of certifier	bee	Pr	W		290		1319				FEBR		Day, Year) 27, 2012	
12%		30. Name and address LORETO							AVE	. #30)5, H	BETHESD.	Α, Μ	MD	2081	4	
State	е	31. Date filed (Mont.	h, Day, Year)	2012	2. Reg	istrar's Signa	ure A	del.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Year Physician/ Feb 26 9:26A Steven F. Garner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 Cedarmere Rd. Baltimore Owings Mills 8. Date of Birth (Month, Day, Year) Jan 31 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 🔀 M 2 🗆 F Director 214-64-8115 60 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Tes 2 No Owings Mills 10e. Street and Number 10g. Citizen of What Country? Funeral 5 Cedarmere Rd. 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify.white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Training Horse Trainer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Harry A. Garner Lorna Ayre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna A. Garner-mother Cedarmere Rd., Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 3-1-12 Sykesville, MD 21. Signaty of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home detition Komas 254 E. Main St., Westminster, MD 2115 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerone Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran-Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Epilepsy, spiral sterocit 1 Yes 2 No 3 Probably 4 Unknown this certificate has been ral director, page 2 should Degeneration Dist Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? Chronic Debilitating Bock Poin 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕱 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Karen F. Balitt, M.D. D58676 February 28, 20/1

Registrar
DHMH 17 Rev 7/2009

your old court Road, stire 301 Balkmore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucy P. Gagen February 27, 2012 00:56A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Howard County Columbia Howard Social Security Number 8. Date of Birth Nov. 8, 1929 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 099-22-3089 Director 1 □ M 2 X F 82 NY 28a-f show 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane PV510 21228 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller/ Banking Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John Poplawski Helen Wolpuik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or all Ms. Margaret Gagen (Daughter) 6606 Westshire St., Portage, MI 49024 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/6/2012 Garrison Forest Vet. Owings Mills, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licer U00769 74 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MULTIPLE YEARS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the a 1 ☐ Yes ∠ ✓ 9 ☐ Unknown Unknown signed by t Id be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific D64395 FEBRUARY 27, 2012 0

Registrar

State

6336

CEDAR LANE COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMANIMO

31. Date filed (Month.

			Please	Type or Print in I State of Marylan	d / Depa	artment of	Health and	•		gible.	
	Physicia Medi		Registrar 1. Decedent's Name (First, Middle, Last	Goldberg	Cer	tificate of	Death	2. Date of De Month		1 2 Year	3. Time of Death 0609 AM
	Examir	er	4a. Facility Name (if not institution, give : Normwest hosp	street and number) . Fall FR-7		Rand	or Location of Dea	th	4c. Coun	nty of Peath	
	Funeral Director		5. Social Security Number 6. Se 219-14-0842 Usual Residence of Decedent	x 7. Age (In yrs. Ia 88	ast birthday) Yrs.	If Under 1 Year Months Days			th Year) 1924	9. Birthp Count	place (State or Foreign try) MD
	itii witii tile Maryland ms 23a or 28a-f show must be notified at	irector		IMORE 10c. City	y, Town or Loc	B/	ALTIMORE			1	0d. Inside City Limits 1 ☐ Yes 2 🙀 No
1	items 23a or er must be r	neral	10 POMONA SOUTH, 11. Marital Status	#2 12. Was Decedent Ever in U.S	12.1		21208 Hispanic Origin? (S	Procify Voc or No.	10g. Citizen o	USA	
9000	ral", or	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 V Yes 2 No If Yes, Give Year or Dates.	It	f Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)		ace - America lack, White, e ify: W	
		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give H	lent's Usual Occu kind of work done O NOT use retired T CUTTER	during most of wo	rking	16b. Kind of	Business Inc	lustry
/land 2	noun be med withing and Mental Hygiene. s marked other that umatic event, the N	اما	17. Father's Name (First, Middle, Last) SAMUEL GOI	_DBERG			18. Mother's Na	me (First, Middle, KRAL		ne)	
e, Mary	Health and Mealth and		19a. Informant's Name/Relationship (Ty) SHIRLEY GOLDBERG	/WIFE	10 P	OMONA SO	t and Number or ReDUTH, #2		er, City or Town,		
Baltimore,	tment o		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State OHE	emetery, crem B SHAL		PARK 02/2		REISTE	RSTOWN	I, MD
Ba	Impo Impo any ir		21. Signature of Funeral Service License	00	89	000 REIS	ess of Facility SC TERSTOWN	ROAD, P	IKESVIL		
	nysician/ Medical Examiner		23a. Party Enter th. disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	lications that caused the deathe cause on each line. a	ny ho	n.6		c or respiratory ar	rest,		Approximate Interval Between Onset and Death
7		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ		issech	°			+	
be executed	ysician and e burial-transit	<u>a</u>	that initiated events resulting in death) Last	Due to (or as a consequence)	ence of):						
. Box 68760	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗔	Ectopic pregnar Other (specify)	псу			Date of delive	ery Day Year
ds, P.O.	within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	ted by Pl	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.				e cause of death?
Vital Records,	rate has ber page 2 sho	Complet						24a. Was autoj perfo 1 Yes	osy ormed?	were autop prior to con death? 1 \(\sum \) Yes	osy findings available inpletion of cause of
ital Sician:	certific rector,	a l	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:		041	Place of Death (Che		-		
of V	er this neral di	ie: 10	27. Manner of Death		ER/Outpatien 28b. Time of	28c. Inju	4 ∟J Nursing I ry at	dome 5 Resid			
ion endin	eath. or, Aft he fur	ficat	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		injury	M 1 🗆	k?] Yes 2 □ No				
Division of	urs after d sral Direct	al Certificate:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	·			28f. Location (S City or Tow	ın, State)		
e Hos	n 24 ho ne Fune pleted	Medical	(Check 2 \square Medical Examin	cian: To the best of my knowled er: On the basis of examination Practioner: To the best of my	and/or investi	igation, in my opin	ion, death occurred	at the time date a	ind place and d	ue to the cau	se(s) and manner stated.
٩	withi To th		29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month, D	
_	10		30. Name and address of person who co	empleted cause of death (Item	23a) (Type, P	rint) NWH	ф\$6879 ER-7				
Ę	Stat Registra	-	31. Date filed (Month, Day, Year) FEB 2 8 2012	32. Registrar's Signatu							

Registrar
DHMH 17 Rev 06-2011

State

AT2438946

201 East University PKWY, Baltimore MD 21218 Union Memorial

2/24/12

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Yaghi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ RHEDA FEBRUARY 2012 GOLDMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country) Director 579-10-4395 1 🗆 M 2 🕱 F 89 04/15/1922 DC 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ed other than "natural", or items 23a or 28a-f s event, the Medi al Examiner must be notified 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7902 BRYNMOR COURT, #602 USA 21208 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 🛚 Widowed 4 🗆 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? is marked o ဂ္ SAMUEL **GREENSPAN** MAY COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Department of Health Important: If item 27 any injury or other the 17 HAMBLETON COURT, BALTIMORE, MD 21208 GAIL BROOKS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 02/26/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Lic-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi ettending physician and or use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the all g Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 2 🗀 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this etely filled in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. work? 1 \sum Yes 2 \sum No 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

one)

nature and title of ce

Name and add less of person who completed cause of death (Item 23a) (Type, Print) alreen 6701 · Cheeles

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0071287

#4105, Balthune, MO, 21204

3 Cectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State State Registrar	e of Maryland / Depa <i>Ce</i>	rtificate of De		Reg. N	/111/	05850
	Dhysisis		Decedent's Name (First, Middle, Last)				Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic	al	MERRILL J. GANN 4a. Facility Name (If not institution, give street as	and number)	4b. City, Town, or Loc		BRUARY	24 2012 c. County of Death	05:40 A M
Ì	Examin	er	MANOR CARE RUXTON	ia namber)	TOWSON			BALTIM	
^-	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 E	7. Age (In yrs. last birthday, Yrs.		Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea 1/24/1923	9. Birth Cou	place (State or Foreign ntry) MD
	land ow	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	MD BALTIMORE	PIK	ESVILLE				1 □ Yes 2 ▼No
	h with the 23a or 28 1st be no	al Director	10e. Street and Number 7 SLADE AVENUE, APT.		10f. Zip Code 21208			Citizen of What Cou	ntry? JSA
980	2 should be filed within 72 hours after death with the Maryland named Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Mucical Eventines must be notified at	by Funeral	1 Never Married 2 Married 1 Married 1 M	Yes 2□No	Was Decedent of Hispa If Yes, specify Cuban, N 1 □Yes 2 🏋 No S	anic Origin? (Specif Mexican, Puerto Ric Specify:			etc. WHITE
Maryland 21215-0036	thin 72 ho ie. an "natul Madical	Completed	15. Decedent's Education (Specify only highest grade complete in the complete	eted) (Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	on ing most of working	16b.	Kind of Business/Ir	ndustry
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auc	ihould be filed and Mental Hygi marked other matic event, II	To Be	HARRY GAN	N		LENA		GOLDST	EIN
_	7 TO 1		19a. Informant's Name/Relationship (Type. Prin HELEN GANN/WIFE		ling Address (Street and		D5 PIKES	SVILLE, M	D 21208
altimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Remova	IIOIII State	osition (Name of ematory or other place)	Date		Location - City or T	
<u>=</u>	nit. Pagartmen artmen ortant; injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funoral Service Licensee	BETH TFI	22. Name and Address	02/26/2 of Facility SOL	I FV I NSO	TIMORE, V & BROS.	MD , INC.
Ba	permit. Departitinports any inji		1 95	8	900 REISTER	RSTOWN ROA	AD, PIKI		MD 21208
	Physician		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	e on each line.			espiratory arrest,		Approximate Interval Between Onset and Death
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68760, 5	rificate be executed in physician and as the burial-transit	al Exa	resulting in death) Last	ue to (or as a consequence of):					
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Division of Vital Records,	icìan: The law rec certificate has bee ector, page 2 shou	Completed					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
ita	stan:] ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Death (
of \	Physic er this o eral dire		1 ☐ Yes 2 🗷 No	Date of Injury 28b. Time	of 28c. Injury a	at 28	d. Describe how i	e 6 ☐ Other (Spe njury occurred	cify)
ion	ending Feath. or: After he funer	ation	2 Accident investigation		M 1 □Ye	es 2 No			
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28€	. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28	f. Location (Stree City or Town, S	t and Number or Ru tate)	irai Houte Number,
)	To the Hospital or within 24 hours after To the Funeral Dirthe completely filled in In	Medical ((Check only_ 2 Medical Examiner: C	To the best of my knowledge, de n the basis of examination and/or nd manner stated.	ath occurred at the time investigation, in my opin	e, date and place, ar nion, death occurred	nd due to the caus d at the time, date	se(s) and manner a and place, and due	s stated. to the cause(s)
,	To the within 2 To the comple	Mec	29b. Signature and title of certifier	mainer stated.	29c. License r	number	29d.	Date signed (Mont	h, Day, Year)
			aguira Fr	mp	R	32808		02/2-	1/2012
	10		30. Name and address of person who complet	-0 -0	- 0 . 1	125,808	SUB	312	4
	Sta		31. Date filed (Month, Day, Year) FER 2. 8 2012	32. Registrar's Signature	barles	- ALANA)	1411)	3130	
	Regist	ror	I MARY 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	I Branch J III . No					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	State of Ma		d / Depa		f Heal	Ith and N	/lental Hyg	iene	gible.	กรร	251	
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)	Mary The	resa G		incate c	Dea		2. Date of Deat February	eg. No. <u>/</u> h 26	2012	3. Time of 1:42		
Medic Examin		4a. Facility Name (if not institution, give st Gilchrist Hospice Center	treet and number)			4b. City, Tow		tion of Death		4c. Coun	ty of Death Baltin	nore		
Funeral Director			X M 2 □ F 7. Age	e (In yrs. las 81	st birthday) Yrs.	If Under 1 You Months Da		nder 24 Hrs. urs Min.	8. Date of Birth	M930	9, Birthp Count	ace (State or Yaryland	r Foreign	
faryland 8a-f show tified at	ector	Usual Residence of Decedent 10a. State 10b. County MD		10c. City,	Town or Loc	cation	Ва	altimore	<u> </u>		11	Od. Inside Cit		
with the N s 23a or 28	Funeral Director	10e. Street and Number 7838 Shepherd Avenue				10f. Zip Coo		21234	1	0g. Citizen o	f What Coun			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	ver in U.S. No		Vas Decedent Yes, specify C		c Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)		ace - America ack, White, e			
vithin 72 hou giene. er than "nat the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	(Give H	ent's Usual Oc ind of work do NOT use retii He	ne during		ing	16b. Kind of	Business/Inc			
uld be filed a Mental Hyg narked oth	To Be		George Klein				18. 1	Vother's Nam	(First, Middle, Maiden Surname) Helen Mann Route Number, City or Town, State, Zip Code) MD 21234					
and 2 shou lealth and im 27 is n her traum		19a. Informant's Name/Relationship (Typ Judy Glace / Daughter	e, Print)		7838 5	Shepherd	Ave., F		, MD 2123 ²	1				
Page 1 a		20a. Method of Disposition 1	Removal from State	ce	metery, cren	sition (Name of atory or other ike Crema	place)	1	Date 20c. Location - City or Town, State Beltsville, MD					
permit Depart Impor any in		21. Signature of Funeral Service Licenser Dorota Marshall	ich W.	laisl		Name and Ac			ices, PO BO	X 1413	Baltimor	e, MD 2	1203	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused cause on each line Due to (or as a	tast	alīe	r the mode of	Julying, suc	ch as cardiac d		st,	,	Approximate Interval Betv Onset and D	veen Jeath	
- #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a				7							
be ey siciar buriz	cal	resulting in death) Last	Due to (or as a	conseque	ence oi):									
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the lines.	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live Birth 1 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3 🗌	Ectopic pregr Other (specify					ate of delive		'ear	
quires that the on signed by sould be deta		Part II. Other significant conditions con	tributing to death bu	ut not resul	Iting in the u	nderlying caus	e given in	Part I.		eacco use col				
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ysician s certifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital;	ent 2 F	- R/Outpatien		Othor:	Death (Check	k o <i>nly on</i> e) ome 5 □ Reside	nce 6 190t	her (Specify)	Harpi		
ending Ph eath. or: After thi the funeral	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injur (Month, Day,	у 2	28b. Time of injury	28c. li	njury at vork?		28d. Describe ho			110		
ital or Att urs after d ral Direct lled in by		4 Homicide determined	28e. Place of Inju- building, etc.	(Specify)					28f. Location (Str City or Town	State)	_		er,	
the Hospi nin 24 hou the Funer npletely fi	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of ex	amination a	and/or invest	gation, in my o	oinion, dea	ath occurred at	the time, date and	d place, and d	lue to the cau	se(s) and mar	ner stated.	
viiti O O		29b. Signature and title of certifier		MT			ense numi		2	9d. Date sign	ed (Month, D	ay, Year) 2		
HV		30. Name and address of person who con					0.55	·	C Dn.	7 0	To ALD			
Stat Registra	State 31. Date filed (Month, Day, Year) State FEB 2 8 2012 ARATHT KUMAR GFOIN CHARLES ST SUTTE 4105 RALTIMORE MD 32 Tegistrar's Signature ARATHT KUMAR GFOIN CHARLES ST SUTTE 4105 RALTIMORE MD 32 Tegistrar's Signature ARATHT KUMAR GFOIN CHARLES ST SUTTE 4105 RALTIMORE MD													

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20,3ear Month Da 242 Gene 4a. Facility Name (if not institution, City, Town, or Location of Death County of Deatl ec DIR 8. Date of Birth (Month, Day, Jan. 11 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 🕅 M 2 🗆 F Hours Pennsylvania 184-28-1504 1935 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Marvland Harford Darlington 1 🗌 Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21034 United States 2507 Shureslanding Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian 1 XYes 2 No 1955-If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: Specify: 1958 White 3 ♥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Fishing Supplies Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) J. Edgar Hess Thelma Suloff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 507 Baron Road, North East, Maryland 21901 Matthew J. Hess/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Metro Crematory Inc 02/22/2012 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MPHOMA Bry Rosen Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar and attending physician Division of Vital Records, P.O. Box 68760 use as for been signed by the sahould be detached it page 2 s has this certificate After

Examine Be Completed by Physician/Medical 2 Medical Certificate: To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shoven

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once.

Physician/

Medical

Baltimore, Maryland

Known

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Director

Completed by Funeral

Be

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Physician: Hess, Jere

	- d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ppic pregnancy er (specify)		23d. Date of delivery Month Day Year
	contributing to death but not resulting in the underly		23e. Did tobacco	use contribute to the cause of death?
chronic obst	ructive Pulmona	y Disease	1 🗆 Yes	2 □ No 3 □ Probably 4 → Unknown
Cardionyop Atrial fibr	athy "		24a. Was an autopsy performed?	
25. Was case referred to medical		26. Place of Death (Check	only one)	
examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 🗓 Nursing Hon	ne 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		work?	8d. Describe how inj	ury occurred
3 Suicide 6 Could not 4 Homicide determined		ctory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
(Check 2 Medical Exar	ysician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigation are a Fraction on To the best of my movined and cet	n, in my opinion, death occurred at t	the time, date and pla	ce, and due to the cause(s) and manner stated.
29b. Signature and title of certifier	2 (/	29c. License number	29d. [Date signed (Month, Day, Year)

20

State Registrar Dr. M.A. Santor, Circle Drive, Perry Point, Maryland 21902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1050 M Physician/ CAROL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign last birthday) Funeral Days Min. 1 □ M 2 🂢 F 76 Hours (Month, Day, June 1 Virginia 223-46-9978 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12410 Glissans Mill Road 21771 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced White the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Alford Wood Etta Louise Hickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Collingham: Daughter 12410 Glissans Mill Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation. Inc. 2-29-12 Hanover Maryland
22. Name and Address of Facility Marzullo Funeral Chapel, P.A. injury (21. Signature of Funeral Service Licensee michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition SEPSIS Ph_sician/) Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death
Unknown Ves 2 No 9 Unknown Division of Vital Records, P.O. þ s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ENDOMETRIAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed Yes 2 No this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident
Suicide within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the P within 2 To the P 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4454 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

FEB 2 8 2012

GANATHAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEMS 10a-f per int g925 3-16-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2012 10:05 Рм Angelea Coffman Haines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Inpatient Care Center Anne Arundel Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Dec. 12, 1924 West Virginia 1 □ M 2 💢 F 234-38-8153 87 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location **Bowie** of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho
other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Prince Geor' Maryland 1X Yes 2 No Auguota 10f. Zip Code 20715 10g. Citizen of What Country? 12212 Millstream by Funeral $\frac{26704}{}$ U.S.A. 71 Bux 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Blanche Billmeyer Lank Coffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : 12212 Millstream Dr., Bowie, MD 20715 (Daughter) Debi Bujac 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Salem Cemetery 1 X Burial 2 Cremation 3 Removal from State 0 Department o Important: If any injury or once, 2/20/2012 Points, WV 4 ☐ Donation 5 ☐ Other (Specify) 2.Name and Address of Facility etropolitan Funeral Service 517 Vine St., Alexandria, VA . Signature of Funeral Service Licensee un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No Day Year Pregnant at time of death ed by the a g ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be def Completed by Critical Aortic Stenosis 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 🔲 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 012 0 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARROTT MD 445 Defense Hwy., Annapolis, MD 21401 31. Date filed (Month Day 37 Registrar's Signat State

Registrar

			Please Type or Print in AMEND ITEM#1 1 - State State Registrar	Black In 9b, perf nd/Depa perff,	delible Ink. Ensure A H, g925, 3,6/2012 Hynent 95 Health and N	II Copies A i WS Iental Hygier	re Legible.					
			State Registrar 1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. No. 2							
Г	Physicia		Joyce Lynne	Hill		Month February	Day Year					
Siene.	Medic Examin		4a. Facility Name (if not institution, give street and number) 3002 Woodhome Avenue	4b. City, Town, or Location of Death Parkville	r cor adr	4c. County of Death Baltimore						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 1984) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 3/16/195/	9. Birthplace (State or Foreign Country) Maryland						
	and show	tor		ity, Town or Loca			10d. Inside City Limits					
	28a-f	Director	Maryland Baltimore		Parkville		1 □ Yes ※XXNo					
	ith the		10e. Street and Number		10f. Zip Code 21234		Citizen of What Country?					
	ems 2	Funeral	3002 Woodhome Avenue 11. Marital Status 12. Was Decedent Ever in U.	.S. 13. W	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,					
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ▼ Married 1 ☐ Yes X X No If Yes, Give Year or Dates.		Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White					
15-(72 hou "natu ledica	nplei	15. Decedent's Education (Specify only highest grade completed)	(Give kii	ent's Usual Occupation Ind of work done during most of work INOT use retired)	<i>ng</i> 16b	16b. Kind of Business/Industry Parkville					
212	led within 7 Hygiene. other than ent, the Me		Elementary/Secondary (0-12) College (1-4 or 5+)		EO/Owner		Lock and Key					
pu	B F F E	To Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide						
Maryland	should be file and Mental I is marked o raumatic eve	-	H.P. Crawford 19a. Informant's Name/Relationship (Type, Print)		No.	ramani						
	2 ± 2 ±	100	Charles Lynnwood Hill — Scouse	195 Mailing Address (Street and Number or Rural I			ille, Maryland 21234					
Baltimore,	of Hea of Hea of Hea if item		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State	Place of Disposi cemetery, crema	ition (Name of atory or other place)	Date 20c	. Location - City or Town, State					
tim	t. Page tment rtant; njury o		4 Donation 5 Other (Specify)	ns Funera metion Se	atory or other place) al Chapel & Privings Pelair 3-2	-2012 Fo	rest Hill, Maryland					
Bal	permit. Page 1 al Department of H Important: If itel any injury or oth	Ų.	21. Signature of Funeral Service Licensee		vans Funeral Chapel at 1800 Harford Road. Par	nd Cremation wille, Mary	Services — Parkville land 21234					
	Ph _{sician/} Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Betwoonset and Disease or condition. Due to (or as a consequence of):									
90	The law requires that the death certificate be executed at the base been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq c. Due to (or as a c. Due to (or as a c. Due to (or as a c. Due to (or as									
_		Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Fet. 4 ☐ Pregnant at time of a	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year						
ls, P.O.		Completed by Pl	Part II. Other significant conditions contributing to death but not res	,	co use contribute to the cause of death?							
of Vital Records,						24a. Was an autopsy performed 1 \(\sumeq\) Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No					
tal	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)						
ję Vi	S 50	2:	1 Yes 2 XNo 1 Inpatient 2 2 27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of	28c. Injury at	4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)						
o uc		al Certificate:	1 X Natural 5 Pending (Month, Day, Year) injury work? 1 Yes 2 No									
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hbuilding, etc. (Specify		et, factory, office	28f. Location (Street City or Town, St	(Street and Number or Rural Route Number, wn, State)					
	Hospital	Medical	29a. Certifier 1 Certifying Physician: To the best of my know (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of	on and/or investig	gation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner stated.					
	To the I within 2 To the I complet	2	29b. Signature and title of ootifier	29d.	Date signed (Month, Day, Year)							
	(m)		Dad & Minus		1)17207	1	52/17/2012					
	211		13.00	650 C	orteanest. Balt	oMD z	1287					
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signa FEB 2 8 2012	has	Red							

Physician/ Medical

Examiner

Funeral

Director

Examiner

29b. Signature and title of

31. Date filed (Month, Day. Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)
BENADETTE MAKORI -NELSON, MD 71

Medical Certificate: To Be Completed by Physician/Medical

To Be Completed by Funeral Director

Please 1	Type or Pring State of Ma						_	ible.	
For State Registrar	State of Ma		ertificate of		IG IVICI		. No. 2	112 05050	
1. Decedent's Name (First, Middle, Last) Joseph Edwar	rd Hakes					Date of Death Month		Year 2012 9.07 P M	
4a. Facility Name (if not institution, give st SAINT JOSEPH M	EDICAL C	ENTER	TOWS				BAL County	TIMORE	
5. Social Security Number 378–36–2263 Usual Residence of Decedent	7. Age K M 2 □ F	(In yrs. last birthda) 95 Yrs.	Months Day			Date of Birth (Month, Day, Ye Ctober 1916	22,	9. Birthplace (State or Foreign Country) New York, New York	
Maryland Baltime	ore	10c. City, Town or	Location	Parkvil	.le			10d. Inside City Limits 1 ☐ Yes 2XXNo	
10e. Street and Number 8800 Walther Blvd	•		10f. Zip Code	21234			nited	What Country? States Merica	
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates.		3. Was Decedent of If Yes, specify Cu	ıban, Mexican, P	? (Specify uerto Rica	Yes or No- n, etc.)	Black	e - American Indian, k, White, etc. white	
15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Gir	cedent's Usual Occ ve kind of work don DO NOT use retire Lege Admi	e during most of ed)	_	16	b. Kind of Bu	isiness/Industry	
17. Father's Name (First, Middle, Last) Joseph Willia		+ (011	rege Adill	18. Mother's	Name (Fil	rst, Middle, Maid • Faron	den Surname,		
19a. Informant's Name/Relationship (Type James T. Hakes/ se		19b. Ma	ailing Address (Stre 303 Glen	et and Number o Arbor Ct	r Rural Ro	ute Number, Cit lanta,	y or Town, Si Georgi	tate, Zip Code) .a 30319	
20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Fulleral Service Censee		20b. Place of Discemetery, c Evans I Chape	22. Name and Add Peaceful A	r 2	Febru 26, 2 es Fun	ary 012 eral and	Forest Cremeti	City or Town, State Hill, Maryland on Center, P.A.	
23a: Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Cause on each line.	the death. Do not e		C. 10				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
that initiated events resulting in death) Last	Due to (or as a	consequence of):							
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)				23d. Dat Mor	e of delivery nth Day Year	
Part II. Other significant conditions con	tributing to death bu	t not resulting in th	e underlying cause	given in Part I.		23e. Did tobac	\ .	ibute to the cause of death? 3 Probably 4 Unknown	
						24a. Was an autopsy performe	24b. V p d2 d3	Vere autopsy findings available prior to completion of cause of leath? ☐ Yes 2 ☐ No	
25. Was case referred to medical examiner?	ospital:			Place of Death (Check onl				
1 Yes 2 No Pt 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Ospital: Inpatient 2								
3 Suicide 6 Could not be 4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) (Check Check 2 Medical Examina Certifying Nurse	er: On the basis of exa	amination and/or inv	estigation, in my op	inion, death occur	rred at the	time, date and p	lace, and due	to the cause(s) and manner stated.	

Registrar DHMH 17 Rev 06-2011

State

□egistrar's Signature

29c. License number **D** 72018

7601 OSLER DRIVE TOWSON, MD

29d. Date signed (Month, Day, Year) 3

2012

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month aulette, Hilliard 21:13 M 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 578-84-9717 1 M 2 F 03/04/1964 WASHINGTON, DC or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD PRINCE GEORGE'S **LANHAM** 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 6304 BRIGHTLEA DRIVE 20706 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS TRAINING INSTRUCTOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked of PAUL HAMILTON CAROL HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIGHTLEA DRIVE LANHAM. NAPDEAN HILLARD/HUSBAND MARYLAND 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of XBurial 2 Cremation 3 Removal from State Important: It any injury or once, 4 Donation 5 Other (Specify) FT. LINCOLN CEMETERY 3/3/2012 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Ligense 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pulmonan FIGURES Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Errlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE

Registrar's Signatur

101539

ST, BALTIMORE, MD, 212-01

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 (%)

	1	For State Registrar					ndelible Ink perPHYS artment of H tificate of D			Reg.	00	12	0585	
ician/ edical	/	Decedent's Name (First	fman, S	2. Date of Dea Month			th	Day 1 Year 10 1						
miner		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital					4b. City, Town, or Location of Death Baltimore				4c. County	of Death		
ral tor	1	5. Social Security Numbe 219–28–5218	Sex 7. 1XXX M 2 □ F	7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year Months Days			Hours Min. 8. Date of Birth (Month, Day) July 13,1		th, Day, Yea	y, Year) Country)		nplace (State or Forei ntry)		
]	5	Usual Residence of Dec 10a. State 10b.	1		y, Town or Lo			Journ	10,170			10d. Inside City Limi		
Director		MD 10e. Street and Number			Baltimore 1XX Yes 2 \(\sigma \) N 10f. Zip Code 10g. Citizen of What Country?									
para	runeral	838 West 34th	n Street	-	21211 U.S.A.									
Ž	2	11. Marital Status 1 ☐ Never Married 2XX Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give XX Year or Dates.				In U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼No Specify: Specify: White						, etc.		
Completed	blere		. Decedent's only highest o		3.	(Give	Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry		
Š		Elementary/Secondary (0-12) College (1-4 or 5+) Pu					e. DO NOT use retired) Mechanic Fuel Company							
To Bo		17. Father's Name <i>(First,</i> Gilman Hoff				Name (First, Me Wiles	Name (First, Middle, Maiden Surname) Wiles							
							-		Rural Route Number, City or Town, State, Zip Code)					
		20a. Method of Disposition 1 XX Burial 2 Cr 4 Donation 5	sition (Name of matory or other place metery	e) 2/:	Date 24/2012		altimo							
ouce.		21. Signature of Furneral Service Usansee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211												
an/ cal ner	liei	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Prostate enlargement Due to (or as a consequence of):												
cian/Medical Examine	- 1	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d												
v Physician/Medica	II)SICIAII/IV	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 ves 2 No 9 Unknown 23d. Date of Month									very Day Year			
٤	≥	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unkn												
Completed	aldillo								24a	. Was an autopsy performed Yes 2	12/	prior to c death?	opsy findings availa completion of cause 2 \(\sum \) No	
å	2	25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)												
		27. Manner of Death	Pending	28a. Date of		ER/Outpaties 28b. Time of injury	nt 3 L. DOA	4 L. Nursi	ng Home 5 28d. Des		e 6 L. Oth		fy)	
ifica	ceruncate.	2 Accident 3 Suicide 6			Yes 2 No	28f. Loca	ation <i>(Stree</i> or <i>Town</i> , S		er or Run	al Route Number,				
الح الح		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
Podical Car	<u>v</u>	only one) 3 🗔 🕻	⊿eruivi⊓α PN	proe Fractitioner: I	o the nest of t	ny knowiedge	, death occurred at the	in time, date a	ina piace, and t	age to the Ca	audoja) aliu i	manifer de	Juliou.	
Medical Cortific		29b. Signature and title		- P()		29c. License	number	213	29d.	Date signe	Month.	, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

item 14 per fh g925 3-2-12 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 25, 2012 5:40 P Patricia Leilani Harris Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 286-52-4358 1 🗆 M 2 🔀 F Yrs August 7, 1950 Ohio 61 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits notified at Director Maryland Harford Joppa 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? items 23a or ner must be n Funeral 202 Fitzhugh Road 21085 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 by 1 Never Married 2 X Married 2 X No Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 72 than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ဂ Page 1 and 2 should be ment of Health and Ments John Edward Bennett Jr. Mary Elizabeth Silva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Jesse Harris / Husband 202 Fitzhugh Road, Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Svcs, LLC 2-29-2012 Bel Air, Maryland McComas Funeral Home, P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility (Jessee & weaver 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) More than Examiner 5 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): requires that the death certificate be IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy performed? Yes 2 N 2 \square No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Ninpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29h. Signature and title 29d. Date signed (Month. Day, Year) D0053568 ake Drive sape ad address of person who completed cause of death (Item 23a) (Type, Print) Year) 62. Registrar's Signature State 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	partment of Health and N							
			Tregiod di	ertificate of Death	Reg. No. 2012 0586U						
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Kun-yen Huang		2. Date of Death Month Day Year 1:10 A M						
	Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
-/			Manor Care	Potomac // If Under 1 Year If Under 24 Hrs.	Montgomery						
	Funeral Director		5. Social Security Number 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda) 7. Security Number 7. Age (In yrs. last birthda) 7	Months Days Hours Min.	8. Date of Birth December 11, 1933 9. Birthplace (State or Foreign Country) Taiwan						
	d t t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits						
	arylan a-f st fied a	Director	Maryland Montgomery Bethe		1 ☐ Yes 2 🛣 No						
	or 28	٥	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
	s 23a	Funeral	8300 Burdette Road, D430	20817	United States						
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto Yes 2 M No Specify: 	acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Asian						
9-0	hours natur lical E	lete	15. Decedent's Education 16a. De	cedent's Usual Occupation ve kind of work done during most of work	16b. Kind of Business Industry						
21	nin 72 ne. than " e Mec	ошо	Flementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	Medical/ Medical School						
72	d with	Be C	17. Father's Name (First, Middle, Last)	sician / Professor	e (First, Middle, Maiden Surname)						
lano	be file ental } ked o ic eve	10	Heng Chi Huang	Tsa M	` <u>_</u>						
ary	hould and Mi s mar				al Route Number, City or Town, State, Zip Code)						
Σ	nd 2 s ealth a m 27 i			D Burdette Road, D4	30, Bethesda, Maryland 20817						
Baltimore, Maryland 21215-0036	. Page 1 al Iment of H tant: If ite jury or ott		1 ☐ Burial 2 ဳ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	y Crematorium, Inc. 201							
Balt	permit Depart Import any inj once,	1			ral Home, Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3501						
			23a. Part 1/Inter the disease, or complications that caused the death. Do not enhock or heart failure. List only one cause on each line.	Parkinson's to thrive A arrery Di	or respiratory arrest, Approximate Interval Between Onset and Death						
	nysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	YATRINSON S	<i>5.</i> 3(4 3)						
عمر مدرست	Examiner		Foilure	to thrive							
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Contany Di	02000						
	ecuted and -transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):	1 Chrony Ch	3 (4) (
0	ate be executed bhysician and the burial-transit	dical E	Tooling in county Last								
3760	ficate g physas the	Nedi	- d								
Box 687	eath certificat attending ph	an/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	23d. Date of delivery							
Bo	e death the att	Physician/Me	If the past 12 months? 4 □ Pregnant at time of death 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	5 Other (specify)	Month Day Year						
P.O.	requires that the de been signed by the should be detached	by Pf	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?							
ds,	quires en sig ould bu	ted b		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔽 Unknown							
COL	law rei nas be e 2 sho	Completed		24a. Was an autopsy performed? 24b. Were autopsy findings availab prior to completion of cause o death?							
Be	r: The icate I		25. Was case referred to medical	00 PL 10 H (0)	1 Yes 2 No 1 Yes 2 No						
/ita	siciar certii lirecto	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Chec	ome 5 Residence 6 Other (Specify)						
of/	g Phy er this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at 28d. Describe how injury occurred							
ion	eath. or: Aff the fur	ifica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	al or Att s after d I Direct d in by 1	Certificate:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours affer death. To the Funeral Birector: Affer this certificate has been signed by the attending ply completed filled in by the funeral director, page 2 should be detached for use as the property of the funeral director.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, dea	vestigation, in my opinion, death occurred a	it the time, date and place, and due to the cause(s) and manner stated.						
	To the vithing compared to the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
	•	Drinky Sings MD 00057458 2/21/12									
_				e, Print) Avenue, #305, Bethe	sda, Maryland 20814						
	Stat Registra		31. Date filed (Month, Day, Year) Segretrar's Signature 32. Egyptrar's Signature 32. Egyptrar's Signature 33. April 2012								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 05861 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB Physician/ Ricardo Ibanez 1210 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES BALTIMORE HOSPITAL N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F 214-36-9758 91 ຶ່າ 920 **Director** Apr Peru Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2 X No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 719 Maiden Choice Lane, HR514 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: White Peruvian Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medical Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucas Ibanez Gregoria Ibanez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 Light Street, Baltimore, Maryland 21228 Ted Simon / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 15 ☐ Other (Specify) Metro Crematory Inc 02/27/12 Baltimore, Maryland Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland In 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner da Esquestially list or dito e, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No ☐ Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 100 Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural $5 \square$ Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) W.

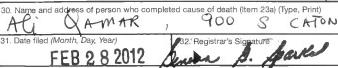
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Registrar

31. Date filed (Month, Day, **FEB 28**



A-ve

Baltimore, 21229, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Martin M. Jacobson 2:20 A February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 604 Clubside Drive Taneytown Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ₹ M 2 □ F Days OCL. 7. 1933 213-32-4099 78 Maryland Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Taneytown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 21787 United States 604 Clubside Drive Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19!
If Yes, Give 19! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1954 1956 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) accounting accountant Be 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot ည Henry Jacobson Dora Schapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Clubside Drive Taneytown, Maryland 21787 Rochelle Jacobson / wife permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 6 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 1, Baltimore Hebrew Cemetery Reisterstown, Maryland 4 Donation 5 Other (Specify) 2012 Eline Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 934 South Main Street M01072 Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 No 1 Yes 2 1 N Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Investigation
6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Taparker bres

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Physicia Vical Exami		1. Decedent's Name (First, Middle, Last) To Parker, Tones				2. Date of De Month	eath Day Year	3. Time of Death 0235 hrs
Ì		4a. Facility Name (if not institution, give street and number)		o. City, Town, or L	ocation of Deal	February	4c. County of	
		Prince Georges Hospital Center		Cheverly			Prince Ge	eorge's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Min		111988	9. Birthplace (State or Foreign Coching for Country)
AOY		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	n			7, 7, 7, 7, 7	10d. Inside City Limits
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MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	ဌ	Judean Jones/mother					mber, City or Town,	State, Zip Code)
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	2	29b. Signature and title of certifier		29c. License n			29d. Date signed	
	-	Vanch Pouthell, mo		O.C.M.I	E.		February 3, 2	012
	d	30. Name and address of person who completed cause of death (Item 23a Pamela E. Southall, MD Assistant Medical Examin		/. Baltimore S	Street, Baltin	nore, MD 21	1223	
Staf	e 3	11. Date filed (Month FEB 2 8 2012 32. Rejistrar's Signature	1. ba				_	
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Baltimore, permit. Pages 1 an Department of Her Important: If ite	L,	21. Signature of Funeral Service Licensee	22. Name and Address of Fac Evan Funeral	Chapel & Crem	ation Services	Parkville
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated.				
	2	29b. Signature and title of certifier	29c. License number	er	29d. Date signed (Mor February 24, 201	
	ļ	30. Name and address of person who completed cause of death (Item 23:			Goldary 24, 201	-
		Donna M. Vincenti, MD Assistant Medical Examine		et, Baltimore, MD 2	1223	
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Baltimore, Maryland 21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates.	If	Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Blac	e - American Indian, ek, White, etc. BLACK
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mol	age 1 ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crem	atory or other place	· •	Date		City or Town, State
altii	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	0 O		OLN CEMET Name and Addres				OOD, MARYLAND ERAL HOME, INC.
<u>m</u>	8858		K.D. Y-ha		74	474 LANDO	VER ROAI	HYATTS	VILLE, MA	RYLAND 20785
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the death cause on each line.	n. Do not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	RESPIRATORY		T				Onset and Death
	Examiner			Due to (or as a consequ FAILURE TO						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or \$6.8 nonsequ						
	cuted and transi	хаш	Cause (Disease or injury that initiated events c.	UTERINE CAN						
	cate be executed physician and s the burial-transi	edical Examiner	resulting in death) Last	Due to (or as a consequ	ence of):					
68760	icate l phys s the		d.							
89	aath certificate be executed attending physician and for use as the burial-transit	Physician/M	Zob. Was decedent pregnant	If yes, outcome of pregnar		Fotonio pre-sus-			23d. Date	e of delivery
P.O. Box	requires that the death certi been signed by the attendin should be detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of d		Other (specify)	y 		Mon	
o.	at the d by t detack		Part II. Other significant conditions contri		ulting in the un	derlying cause give	en in Part I.	220 Did to	phagos uso contril	bute to the cause of death?
S, F	ires the signer of signer of the signer of t	Completed by	ASCITIS			, , ,		1 🗆		3 Probably 4 Unknown
Division of Vital Records,	w requ	plete	METASTATIC CANCER					24a. Was		Vere autopsy findings available
Rec	Physician: The law this certificate has ral director, page 2	mo.						autor perfo 1 Yes	rmed? de	rior to completion of cause of eath?
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	-14-1		26. Pla	ice of Death (Che		2 LX(10)	163 2 1140
Ž	Physi this c ral dire	၉	T Tes 2 to No	pital: 1 Inpatient 2 I			4 Lx Nursing H		lence 6 🗆 Other	
0 0	iding P th. After t funera	cate	1 August 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at ? Yes 2 □ No	28d. Describe h	ow injury occurred	d
isio	tal or Attendir s after death. al Director; Aft ed in by the fu	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, farm, stree		163 Z LJ NO			r or Rural Route Number,
^	ital or irs afte al Dir led in			building, etc. (Specify)				City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 \(\subseteq \text{Medical Examiner:} \)	n: To the best of my knowle On the basis of examination actitioner: To the best of m	and/or investig	ation, in my opinior	death occurred:	at the time date a	nd place, and due:	to the cause/s) and manner stated
	Vithi To th		29b. Signature and title of cortifier			29c. License				(Month, Day, Year)
	- A.A.			4		D196	509		FEBRUARY	27, 2012
	5 M		30. Name and address of person who comp				0.1.7			
	Stat	e	31. Date filed (Month, Day, Year)	0810 DARNEST			GALTHERS	SBURG, MA	RYLAND 2	:08/9
	Registra		FEB 2 8 2012	ann B.	a gas	Mari				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month FEB Physician Year RUTH JONES 2012 4-12 fmM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kandallstown enesis an dalls town saltimore Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC **Funeral** 1□M 22F Months Days Hours Min. Year) Director 224402638 1935 Usual Residence of Decedent the Maryland a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD NA 1√ Yes 2 No Baltimore 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2; any injury or other traumatic event, the Medical Formations. 10f. Zîp Code 10g. Citizen of What Country? 3507 Liberty Heights Ave 21215 by Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housekeeping Essex Comm. College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Arnold ပ Laura Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Jones-Daughter 3507 Liberty Heights Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ A
4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Garrison Forest 3/6/2012 Owings Mills, Md 21. Signature of Funer 22. Name and Address of Facility
March F/H West ervice Lice 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** thrive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Division or Vital Records, P.O. the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1□ Yes To the Hospital or Attending Phystcian: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 20 No P 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1/☑Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

00072109

adallstown

M.D

Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 20

BAQ

EB

SADIA

31. Date filed (Month, Day

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

Director

Funeral

Completed by

Be

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Р	lease Type or Pri			_	_	
For State Registrar	State of M		artment of Health a rtificate of Death		iene eg. No.2	05867
1. Decedent's Name (First, M Elaine	liddle, Last) Lill	ian	James	2. Date of Deat Month	Day Year	3. Time of Death
4a. Facility Name (if not institu	ution, give street and number)		4b. City, Town, or Location of		4c. County of Dea	ith
SINAL HOSP	THE OF BAC	TIMORE	BALTIMORE			
5. Social Security Number 133–22–1180	O 1 □ M 2X F	79 Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day,		rthplace (State or Foreign puntry)
Usual Residence of Deceder 10a. State 10b. Co		10c. City, Town or Lo	cation			10d. Inside City Limits
MD	NA	Baltir	nore			1 X Yes 2 ☐ No
10e. Street and Number 4125 Kensha	aw Ave		10f. Zip Code 21215	1	10g. Citizen of What C	
11. Marital Status 1 Never Married 2 3	If Van Civa	No	was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 Yes 2 X No Specify:		14. Race - Am Black, Whi Specify: B	te, etc.
	cedent's Education highest grade completed) -12) College (1-4 or 8	(Give life. D	dent's Usual Occupation kind of work done during most of NOT use retired) etary Manage	of working	16b. Kind of Business Luthervi Manor	s/Industry lle College
17. Father's Name (First, Mide Ford	dle, Last)		18. Mother	r's Name (First, Middle, M Hart	Maiden Surname)	
19a. Informant's Name/Relat	tionship (Type, Print)		ng Address (Street and Number	or Rural Route Number,		
Jerry James	s-Husband	412	5 Kenshaw Av	e, Baltim	ore, Md	21215
20a. Method of Disposition 1 ☐ Burial 2 X Crema 4 ☐ Donation 5 ☐ Ott	ation 3 Removal from State	20b. Place of Dispo cemetery, crei	matory or other place)	Date /27/2012	20c. Location - City of Baltimor	
21. Sign ture of Funeral Serv	rice Licensee		2. Name and Address of Facility arch F/H Wes 300 Wabash A	t ve, Balti	more, Md	21215
23a. Part 1. Enter the diseas shock, or heart fallule. Immediate Cause (Final disease or condition resulting in death)		э.		ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to infunedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	COPE	a consequence of):				10 yvs.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	d	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
	nditions contributing to death to		underlying cause given in Part I.			to the cause of death?
Dementio	λ			24a. Was a autops	med? death?	utopsy findings available o completion of cause of
25. Was case referred to med	dical		26. Place of Death	1 🗌 Yes	2 L Y No 1 ⊔ Y	es 2 V No
examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 ER/Outpatie	Other	rsing Home 5 - Reside	ence 6 Other/Soc	ecify)
27. Manner of Death 1 Natural 5 P 2 Accident In	28a. Date of inju (Month, Da	ry 28b. Time o		28d. Describe ho	ow injury occurred	

Ph_sician/ Medical Examiner anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the s nis certificate has t I director, page 2 s within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or

Medical Certificate: To Be Completed by Physician/Medical Examiner

DIABETES M	ELLITUS, Advanced	1 🌠 Yes 2 □ No 3 □ Probably 4 □ Unknown
Dementia		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check or	nly one)
examiner? 1 Yes 2 Yo	Hospital: 1 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	(<i>Month, Day, Year</i>) injury work? n M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
	sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at the	

only one) 29b. Signature and title of certifie

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

242012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAL HOSPITAL OF BALTIMORE CATHLEEN

RES

-000

State Registrar 31. Date filed (Month, Day, Year) FEB 2 Registrar's Signatur

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JONES Februar Physician/ Ó Medical City, Town, or Location of Deat 4a. Facility Name (if not institution, give street and number, **Examiner** Hospita ohns HOPKINS Baltimore If Unde Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 220-22-2327 88 **Director** 1 □ M 2**X** F 03 10 23 MD Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director Baltimore 1 X Yes 2 No MID NA 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21223 U.S.A. 2210 Penrose Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Black 3√ Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than ılth grade College (1-4 or 5+) Balto. Public Schools Crossing Guard event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be Bessie Johnson Phillip Truiett other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21216$ 2429 Calverton Heights Ave, Baltimore, Sylvia Parmlee-Daughter item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Md 3/6/2012 Owings Mills, Garrison Forest Donation 5 Other (Specify) P2. Name and Address of Eacility BY West 300 Wabash Ave, 21. Sign tura of Funeral Service Licensee Baltimore, Md 21215 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the d shock, or heart fail or complications that re. List only one cause on each Immediate Cause (Fi Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached detached 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4X Unknown 2 No 3 Probably Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perforn 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: ၉ 1 🗌 Yes 20X No 1/X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending 1 Yes 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Minn 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar FEB 2

For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 24,2012 FEBRUARY MICHAEL PAUL JENNINGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **ESSEX** 2006 MARS RUN ROAD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 T F Days Min. Hours JUNE 23, 1948 213-52-5666 63 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland **Funeral Director** MD. BALTO. **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2006 MARS RUN ROAD 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 1 Never Married 2 X Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12TH College (1-4 or 5+) MACHINIST MECHANIC Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ PAUL G. JENNINGS MARIE E. BAWROSKI Page 1 and 2 should be ment of Health and Ment 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 JUNE JENNINGS SPOUSE 2006 MARS RUN ROAD ESSEX, MD. 21221 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC. Signature of Funeral Service Licensee 6224 EASTERN AVENUE BALTO.MD. 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure ast only one cause on each line. Immediate Cause (Final Physician/ Kesprato disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and to (or as a consequence of) death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed? Yes 2 N the Hospital or Attending Physician: Was case referred to medic 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

8:35P

9. Birthplace (State or Foreign

10d. Inside City Limits

WHITE

1 Yes 2 No

BALTO.

USA

Specify

14. Race - American Indian, Black, White, etc.

AUTOMOTIVE

15 CASE

23d. Date of delivery

death? 1 Yes 2 No

Day

24b. Were autopsy findings available prior to completion of cause of

Year

Month

GLEN BURNIE, MD.

Approximate

Interval Between

MARYLAND

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cause of death (Item 23a) (Type, Print) Eastern Ave baltenine 32. Registrar's Signature

State Registrar (Check

only one)

29b. Signature and title of certifier

SHEZDON H. GOT

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HATIM NABIH JABAJI 12:31 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita astdale Villare If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 241-41-9211 1^X M 2 □ F 50 Country) Director Yrs JORDAN JUNE 8,1961 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 1 🗆 Yes 2 🎖 No ROSEDALE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ò the Medical Examiner must be Funeral 21237 items 23a 5324 LITANY LANE 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married o þ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4 or 5+) than OFFICE OF ENERGY Elementary/Secondary (0-12) Il Hygiene, DIRECTOR CONSERVATION MD STATE other traumatic event, Be 17. Father's Name (First, Middle, Last 18. Mother's Name *(First, Middle, I* LAILA RIZKALLAH and Mental F မ NABIH JABAJI 19a. Informant's Name/Relationship (Type, Print)BROTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 8221 BELL LANE VIENNA, VA 22182 SHUKIRI ABDALLAH- IN LAW 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2/28/12 BALTIMORE, MD DULANEY VALLEY MEM'L 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, of complice shock or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner ancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine 12 or Attending Physician: The law requires that the death certificate be executed and I-trans that initiated events Due to (or as a consequence of resulting in death) Last burialsician Physician/Medical Records, P.O. Box 68760 phys the I as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Dav Year Pregnant at time of death 2 No ed by the a 9 Unknown Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? page 2 🗌 No certificate Yes 2 - No 1 Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Man/er of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred ieral Director; After filled in by the funer (Month, Day, Year) Natural 5 Pending M 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 900 MID Baltimore Jacq1 maway Drive tranklin Mare 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Mar	yland / Depa	artment o	f Health	and Mental	Hygien	е	
	1	State Registrar		Cer	tificate o	f Death		Reg. N	10.2015	0587
Physician/	/	I. Decedent's Name (First, Middle, La: Curtis Ri	st) .chard Knu	dsen			2. Date Mont Fel		Day Year 4 2011	3. Time of Death
Medical Examiner		a. Facility Name (if not institution, give			4b. City, Towr	n, or Location			1c. County of Dea	th
		349 Townsend			Esse				Baltir	nore
Funeral Director	5			53 Yrs.	If Under 1 Ye Months Day			of Birth th, Day, Year 1117		rthplace (State or Foreign ou <i>ntry)</i> MD
iryland t-f show ied at	Director	Usual Residence of Decedent Oa. State 10b. County MD Balti		Oc. City, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
th the Ma 3a or 28s t be notif	al Dire	0e. Street and Number 349 Townsend	Road		10f. Zip Cod				Citizen of What C	ountry?
0 2.9		Marital Status Never Married 2 Married Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No	1	Vas Decedent o	of Hispanic Ori uban, Mexical	igin? (Specify Yes on n, Puerto Rican, etc	or No-	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 bernit. Page I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o ny injury or other traumatic event, the Medical Exam To Be Completed by	Completed	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gi	rade completed)	(Give	dent's Usual Ockind of work do	ne durina mos	at of working	16b.	Kind of Business	
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, Mar nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (1 Rosalie Knuds					er or Rural Route N Road Bal	timo:	re MD 2	21221
more lar Page 1 ar nent of He ant: If iter ant: If iter ary or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of Dispo cemetery, crer HOLLY	sition (Name of patory or other I 1 1 1 C	emeter	cy 2/28/		Location - City o	
Balti permit. Departn Importa any injt		21. Signature of Puneral Service Licen	Cornelly	A . 22	2. Name and Ad					lto. MD sex 2122 ¹
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6 2 2 6	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						
Box 687 death certificate attending ped for use as	Me.	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregr				23d. Date of d Month	elivery Day Year
es that the signed by I be detac	Dy Ph	Part II. Other significant conditions	contributing to death but	t not resulting in the t	underlying cause	e given in Part	1. 23e			to the cause of death?
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ital Reco	္တိ	25. Was case referred to medical			26	3 Place of De	ath (Check only one		No 1 LI Y	es 2 No
Vital Reco	o Re	examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ER/Outpatie		0	lursing Home 5		6 ☐ Other (Spe	ecify)
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Hospitz 124 hours 5 Funeral letely fille	Medical	(Chock 2 Medical Evan	ysician: To the best of m niner: On the basis of exa rse Practitioner: To the	amination and/or inves	stigation, in my o	pinion, death o	occurred at the time.	, date and pla	ace, and due to the	e cause(s) and manner sta
To the within To the comp	2	29b. Signature and title of certifier	- M.D.			ense number	256		Date signed (Mon	
		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print) Uare Dri	ve Ste a	400 Ralt	imort	mD 2	1237
State	9	31. Date filed (Month Day Year)	32. Registrar	's Signature	Kel					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Andrew C. Kravowski Feb 2012 7 - 57A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Days Hours Min Director 186-18-4252 90 Mav Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10b. County 10c, City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5896 Emory Rd. 21155 USA 12. Was Dicedent Ever in U.S. Armod Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Welder Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kathryn Pontition Michael Krayowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Krayowski-son Main St. Duryea, PA 18642 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 N Removal from State injury 0 4 Donation 5 Other (Specify) Vladmirs 2/29/12 Palmerton, PA 22. Name and Address of Facility Fletcher Funeral Home, 21. Signatura of Funcional Signatura of Funci any 254 E. 21157 Main St. Westminster, MD 23a Dent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate duos. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 2 No the a g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown safter death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 - No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ပ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier 18 23a) (Type, Print) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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vithing comp	29b, Signature an	d title of certifier	gentlet cause of c			29c, License			29d. Da	ate signed	(Month, E	Day, Year)	
	30. Name and add	dress of person who	completed cause of c	leath (Item 23a)	(Type, Pri	int) Falls R	d . Lut	hervil	le.	MD			
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		State Registrar			Certifica	ate of Deatl	h	R	eg. No. 2	112	05874
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Funeral Director		5. Social Security Number 6. Sex 1 1 1 Usual Residence of Decedent	7. Age	(In yrs. last birti 85	hday) If Uni Month		der 24 Hrs. S Min.	8. Date of Birth (Manth Day 10-6-1			place (State or Foreign
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With Con.		29b. Signature and title of certifier			2	9c. License numbe	er	2	9d. Date signed	(Month, E	olay, Year)
17011		30. Name and address of person who comp	bleted cause of dea	ath (Item 23a) (1	Type, Print)	2 Ruco	lw	espon	instr	~ 2	1157

DHMH 17 Rev 7/2009

State Registrar

TARLO MAV 31. Date filed (Month, Day, Year) FEB 2 8 2012

32. Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ February 21, 2012 8:15 AM Catherine Ann Knights Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 3800 Enfield Chase Court #200 Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month, Day, Year) 002-22-9555 81 1 □ M 2 🔏 F **Director** 11/18/1930 NH Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 1 ¥ Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 'natural", or items 23a o dical Examiner must be Funeral 3800 Enfield Chase Court #200 20716 U. S. A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceden 2.5. Armed Forces? 1 ☐ Yes 2 🌠 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph A. Vallev Rubv Smith other traumatic 19a. Informant's Name/Relationship (Type, Print)
, Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other franconce. Sabrina Bethancourt/Representative 15202 Noblewood Lane, Bowie, Maryland 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/25/2012 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Robert E. Evans Funeral Home, Signature of Funeral Service Licensee 22. Name and Address of Facility any in 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician Vallual Causes disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death been signed by the a should be detached f g Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? death? ☐ Yes 2☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 5 Pending 1 Natural work? after death. Director: Af 2 🗌 No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completely fi 29a. Certifier (Check

State Registrar

DHMH 17 Rev 06-201

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

se of death (Item 23a) (Type, Print)

29c. License number

D0829051

occurred at the time, date and place, and due to the cause(s) and manner as stated

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29d. Date signed (Month. Day, Year)

3 Certifying Nurse Practitioner: To the best of my knowledge, death

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32. Registrar's Signature

funeral director, this After t or Attending 4 hours after death.

*uneral Director: A ely filled in by the fu Hospital 24 hours

completely within 2.

Other: Vursing Home 5 Residence 6 Other (Specify) 1 Tes 2 DNO Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 → Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29c. License number

Rd

D69540

29d. Date signed (Month, Day, Year)

suite 204 Parkville MD 21234

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2012.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shah.

Jiyar.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Walmam Words

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:21 PM EBRUAR ROSEMARY KREINER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROSEDALE SQUARE HOSPITAL BALTIMORE FRANKLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 😿 F **Director** 218-42-4956 67 OCTOBER 2,1944 MARYLAND Usual Residence of Dece ms 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5305 TODD AVENUE 21206 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) per "it. Page 1 and 2 should e filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify. Specify: WHITE 3 x Widowed 4 □ Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DRY CLEANERS CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN CORA G. DONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. TAMMY KREINER 1424 LANGFORD ROAD GWYNN OAK, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-28-2012 ATLANTIC CREMATORY GLEN BURNIE, MD. 21. Sign, sure of Fur eral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTO. MD. 21206 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fair . List only one cause on each line Immediate Cause (Final Physician/ RESPIRATOR disease or condition resulting in death) HAILURE Medical **Examiner** N-SMALL LUNG CANCER Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician ar s the burial-t Physician/Medical Box 68760 as IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Yes 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner_of Death 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number,

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year,

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within 2 To the F

and address of person who completed cause of death (Item 23a) (Type, Print)

determined

9000 FRANKLIN SQUARE DRIVE BALTIMORE RAMIR MD

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 20T2 5:58 A M Charles Corneilius Lochary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 825 Conowingo Road Bel Air Social Security Number 6. Sex 1 ★ M 2 ☐ F If Under 1 Year 8. Date of Birth
(Month, Day, Yea 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral Months Days Hours 85 Director 213-26-2982 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 825 Conowingo Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Master Electrical Inspector Harford County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Roberta Harkins Thomas Wilson Lochary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Conowingo Road, Bel Air, Maryland 21014 Sandi J. Ackerman / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-25-2012 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Remo Donation 5 Other (Specify) Cem. St. Ignatius Catholic Forest Hill, MD 21. Si ture of Fu 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ₽nysician/ disease or condition Jears Medical resulting in death) Due to ras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 1 ☐ Yes 2 L 9 ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Mulinum 24b. Were autopsy findings available prior to completion of cause of autopsy death? performe Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, i Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 KResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 💢 Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D53186 2012

Registrar
DHMH 17 Rev 7/2009

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Hickory Ave Ske Bel Ar mo 2019

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tinne

31. Date filed (Month, Day, Year)

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			1 - State of Ma Registrar	aryland / Depa <i>Cen</i>	rtment of H tificate of D			ene g. No. 20	12	05879
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
	Medic Examin	cal	Henry Carlton Lanford 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	Feb. 19.	2012 4c. County		8:00 рм
_) LAGIIIII	ici	Bowie Health Center		Bowie	е			PG	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	e (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 199–16–19	Year) 946	9. Birthpi Count Wash	lace (State or Foreign ry) DC
	nd thow at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10	Od. Inside City Limits
	Maryla 28a-f s otified	irect	MD PG		Bowie					1 X Yes 2 □ No
	with the 23a or 3	Funeral Director	10e. Street and Number 14503 Clover Hill Ter.		10f. Zip Code 2	0720	10	Og. Citizen of V	Vhat Count USA	try?
o500-c	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes ② ☐ If Yes, Give Year or Dates.	No If	/as Decedent of His Yes, specify Cuban ☐ Yes 2 XNo	, Mexican, Puerto		Blac	e - America k, White, e Black	tc.
7212	ithin 72 hou ene. r than "nati the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	+) (Give k	ent's Usual Occupa ind of work done du NOT use retired) MET SETVI	uring most of work	ing	16b. Kind of Bu Safeway		lustry
ylandz	be filed w antal Hygi ked other c event, i	To Be	17. Father's Name (First, Middle, Last) James Lanford	Cuscoi			e (First, Middle, M			·
Mary	d 2 should alth and Me 1 27 is mar r traumati	8	19a. Informant's Name/Relationship (Type, Print) Rosalind T. Lanford/Wife	19b. Mailin	g Address (Street a Clover H	nd Number or Rura ill Terr	al Route Number, (Bowie,	City or Town, S MD 207	tate, Zip C '20	ode)
more,	Page 1 and ent of Her nt: If item ry or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Harmony Me	atory or other place)		20c. Location - Landove	-	
Baltimor	permit. F Departm Importa any inju	100	21 Signature of Funeral Service Licenses		Name and Address					20695
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death. Do not ente	r the mode of dying	, such as cardiac	or respiratory arres	t,		Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a	a consequence of):	yopa	THY	200	JTHM		
	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	a consequence of):	C/784	VIA C	_ // /~/-	7.		
	cate be executed physician and the burial-transit	al Exa	that initiated events C.	a consequence of):		_				
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BOX OS	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Dat	te of delive nth	ery Day Year
s, r.o.	ires that th signed by Id be detac	ρ	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.				e cause of death?
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OT VI	Physic r this c ral dire	2	27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatien	t 3 DOA Other	4 U Nursing Ho	ome 5 Resider			
lon	tending death. tor: Afte the fune	Certificate	1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide 6 Could not be	y, Year) injury	M 1□					5
DIVISION	ital or Aturs after or al Direction by		building, etc				28f. Location (Str. City or Town,	State)		
	n 24 hol n 24 hol ne Fune oleted fi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practioner: To the	xamination and/or investi	igation, in my opinior	n, death occurred a	t the time, date and	I place, and due	e to the cau	se(s) and manner stated.
	To the within complete the comp		29b. Signature and title of certifier		29c. License			2 - 2		
			30. Name and address of person who completed cause of de							
	Sta		Cecil George 7500 Hand 31. Date filed (Month, Day, Year) FEB 2 8 2012	Over Parkwa ar's Signafure	y #101a (Greenbeli	MD			-
	Registra	ar	FED 2 0 CUIL KENDON	10.19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2012 2:06 P M Lance Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday) Days Hours Min (Month, Day, Year) Director 311-30-8992 1 □ M 2 🗓 F Feb 3, 1931 Indiana 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Baltimore Lutherville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 107 Welford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 2 X No þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare n/a Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John William Baumholser Ruth Marie Leigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Kim E. Gentry/Son 2121 Reuter Road, Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/24/12 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 bryan W Clary the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that Approximate Interval Between Onset and Death cause Immediate Cause (Final Ph sician/ disease or condition TASTATIC **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoo use contribute to the cause of death? þ CORONARY ARTERY DISPASE Division of Vital Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 2 DIABOTOS MOCLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 \ No 1 🗌 Yes 2 3 N Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rom MD 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24 Patricia Gale LeCompte 201°2 2:30p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 1410 Woodbine Way Woodbine Carrol1 8. Date of Birth May 6 1935 9. Birthplace (State or Foreign Country) MD . Social Sacurity Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 215-82-9261 Director 1 □ M 2 🗓 F 76 3a or 28a-f show t be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Woodbine Carroll 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a ent, the Medical Examiner must br Funeral 21797 USA 1410 Woodbine Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐XNo Specify: white 3 Widowed 4 N Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) beauty Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th hairdresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jacob Brown Gladys Gill t. Page 1 and 2 should by tment of Health and Mer tant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Dana LeCompte 1142 Colonel Joshua Ct., Westminster, MD 21157 permit. Page 1 and 2 Department of Health Important; If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)
All County Cremation 2/28/2012 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Signature of Funeral Service Line 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cancel Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. if yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) be detached 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending ____ Natural Accident 2 No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29c. License number 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) Mo 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster CHAZICO 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:35P M Levin Gertrude February 2017 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALFIMORE ENVOY OF PIKESVILLE PIKESVILL 7. Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min 1 🗆 M 2 💢 F Director 220-46-7061 100 09/05/1911 Yrs WI Usual Residence of Decedent or 28a-f show he notified at 10d. Inside City Limits 0a. State 10b County 10c. City, Town or Location Director 1 X Yes 2 No MD N/A **BALTIMORE** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? pe 23a Funeral USA must t 3404 FALLSTAFF ROAD 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or item edical Examiner n Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify WHITE Completed 3 X Widowed 4 Divorced than "naturation the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than **HOMEMAKER** the OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uege 1 and 2 should be uepartment of Health and Mental Important If flem 27 is markmany injury or other the once. ဂ္ JOSE PH BENESCH STELLA WINTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2312 CAVESDALE ROAD, OWINGS MILLS, MD 21117 STEVEN GILMAN/SON-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date HAR SINAI CEMETERY 02/2<u>6/2012</u> OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 22. Name and Address of Facility Marte 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cardiovascular Disease Atheros clerotic Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Succeptibility list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) g physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After in pletely filled in by the funer (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

NSRyupuenUM·D

N-S · Rajapakse, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

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. Registrar's Signa

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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2/25/12

Baltimore MD ZIZOG

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar		Cer	tificate of D	eath		Reg. No 2 U	12	05883
	Physicia	n/	Decedent's Name (First, Middle, Last)	1. 5.0				2. Date of Dea	th Day/	Year	3. Time of Death
	Media	al	EMILY IT P	INCOLA				Feb		012	11:32 AM
	Examin	er	4a. Facility Name (if hot institution, give str HOWARD COUNTY (eet and number)	~CD.TA/	4b. City, Town, or	Location of Death		4c. County	of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	Columbia If Under 24 Hrs.	8. Date of Birtl	1	Howa 9 Birtho	ace (State or Foreign
	Director		500 40 7025	M WE E		Months Days	Hours Min.	(Month, Day	Year)	Counti	ry)
	, MO 1		Usual Residence of Decedent 10a. State 10b. County	- 12				03/11/	1939		lissouri
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	or 28a notif	Dire	MD Howar	d	-	10f. Zip Code	Columbia		40. 022 . 124		1X Yes 2 No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Funeral Director				Tot. Zip oode	21044		10g. Citizen of W		ry:
	eath v	-une	10327 Wilde Lake Terrace	. Was Decedent Ever in U		as Decedent of His	21044 spanic Origin? (Spe	ecify Yes or No-	14. Race	USA - America	an Indian.
9	ter de , or it imine	by F	1 Never Married 2 Married	Armed Forces?	If	Yes, specify Cubar	i, Mexican, Puerto	Rican, etc.)		, White, e	
21215-0036	ursa† :ural" al Exa	ted	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates.	1	∐ Yes Ž X ∐ No	Specify:		Specify:	Wh	ite
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	led w Hygi othe	Be	12 17. Father's Name (First, Middle, Last)	4		Real	18. Mother's Nam	e (First, Middle, I		eal Esta	ate
lan	ild be filed Mental Hy larked oth atic event	오	R	oger Taylor				,	ieve Vinvar	d	
Maryland	2 should th and Ma 27 is mar traumati		19a. Informant's Name/Relationship (Type		19b. Mailing	g Address (Street a	nd Number or Rura				ode)
	and 2 s Health tem 27		John Taylor Lincoln / Son		9808 R	unning Ceda	r Lane, India	n Trail, N	C 28079		
Baltimore,	e 1 al t of H if itel		20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐ Re		Place of Dispos cemetery, crem	ition (Name of atory or other place)	Date	20c. Location -	City or Tov	vn, State
턡	t. Page tment o tant: If jury or		4 Donation 5 Other (Specify)		Chesapeak	e Crematory	2/28	/2012	Belt	sville.	MD
Bai	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	1 10 140	(III	Name and Address					
-			Dorota Marshall Voc	ote w. Wes	th. Do not onto	aryland Crer	nation Service	ces, PO BC	X 1413Bal	timore	MD 21203
١,			shock, or heart failure. List only one of immediate Cause (Final	cause on each line.	. N	C .	, such as cardiac c	ir respiratory arre	,		Approximate Interval Between Onset and Death
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Sic	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	I ome, farm, stree			28f. Location (St	reet and Number	or Rural F	Route Number,
2	tal or rs afte al Dir led in			building, etc. (Specif	у)			City or Towr	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	n: To the best of my know On the basis of examination	rledge, death or	curred at the time,	date and place, an	id due to the cau	ise(s) and manne	r as stated	d. se(s) and manner stated.
	thin 2 thin 2 the I		only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractitioner: To the best of	my knowledge, d	death occurred at the	e time, date and pla	ce, and due to th	e cause(s) and ma	nner as sta	ated.
	7 .≱ 6 8		200. Orginatuje ajid tide or certifier	Kas M	0	29c. License	CL C-	2	9d. Date signed	Month, Da	
	7	ŀ	30. Name and address of person who com	pleted cause of death (from	n 23a) (Tunn P	(ut)	207		1-60 /		2012
	121		KIM L GORIA		House	RA COL	N94 G	ENERA	6 HOSP	ITAL	
	Stat		31. Date filed (Month, Day, Year)	32. egistrar's Signa	ature	<i>y y</i>	1441	-140141	- 11	1 1 1	
	Registra	r	FEB 2 8 2012	anewa ,	3. pa	Ken					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joanne Marie Lapp February 23 2012 3:15 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4508 Fieldgreen Drive Nottingham Baitimore Date of Birth (Month, Day, Year) 06/17/1958 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min. Maryland 219-70-0317 53 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the the disal Examinating the notined at Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3507 Pelham Avenue, Fl. 2 21213 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TYES 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Law permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygii Important; If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Markowski Kathleen Kuhns ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jones / Sister 4508 Fieldgreen Road, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/25/2012 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service 1 Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on. law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE asn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No P.O. signed by the 9 TUnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an page 2 s has The certificate 1 ☐ Yes the Hospital or Attending Physician: thin 24 hours after death.
the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Pesickus 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide In 24 hours the Funeral Dire 1🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated.

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within To the

State

31. Date filed (Month, Day, Year)

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29b. Signature and itig

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North Dr. Columb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 29d. Date signed (Month, Day, Year)

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death alizainem McCo. Physician/ Month Day 26 0626M 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Travna Balkmore Mary land Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 213-24-5772 Director 1 M 2 XF Jan.16,1928 MD 84 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Manchester MD Carroll 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21102 Funeral items 23a 3225 Farm Lane USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Force Black White etc. ð 1 Never Married 2 Married Yes 2 🔀 No "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other thornaminjury or other traummer. than Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bridget Isabell Mulligan Bradford Lee Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3225 Farm Lane Manchester MD 21102 Deborah Cross/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Cemetery 3/1/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or compositions that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Fritza Cranial hemorrhag disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 24 hrs Mechanica Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital r Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) by the a Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause fi 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the director, page 2 s autopsy performe Yes 27 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ■ npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Yea 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 2 No 2511 6:00 A Investigation Director of n by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3225 Falm La nanchester, Home within 24 hours a

To the Funeral C

completely filled MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 1861717696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Britimore MD 2/201 Staci Peint 0 22 South Year) State Registrar

		For State Registrar			of Maryla	nd / Dep		t of F	lealth		Mental I	Hygie _{Reg.}	_	12	05886
Physicia Medic		1. Decedent's Name Bar	e (First, Middle, bara	Last)	Mo1	yneux	- •				2. Date of Febru		Day 25, 2	Year 012	3. Time of Death 5:50 A M
Examin	er	4a. Facility Name (if		give street and nu	mber)		4b. City,		Location				4c. County		
Funeral		Maple R 5. Social Security No.		6. Sex	7. Age (In yrs.	last birthday)	If Unde		ckvi.		8. Date of	Birth	MOTI	tgome 9. Birtho	ery Nace (State or Foreign
Director		105-26-9		1 □ M 2 XX F	78	-	Months	Days	Hours	Min.		Day, Yea		Coun	
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with t	Funeral Director	4316 Ro	sedale	Ave.					0814				Jnited		
death items ier m		11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Spe	ecify Yes or l Rican, etc.)	No-		e - Americ	
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f Heal		20a. Method of Disp	position			Place of Disp	osition (Nar	ne of			Date	_	c. Location -		·
Page nent o int: If		1 Donation	Cremation 5 🗌 Other (S)	3 Removal from Decify)	n State Ch	cemetery, cre lesapea	ike Cr	ther plac emat	ory (02/28	3/2012		Belts	ville	e, MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service Li	censee		Ŕ	appe F	dAddre	a1 Facili	Yd C	remati	on S	Servic		10
	-	23a. Part 1. Enter t	he disease, or	complications that	caused the dea						ver Sp		g, MD	209	Approximate
Physician/		shock, or hear Immediate Cause (rt failure. List or Final	nly one cause on e	ach line. .ILURE I						,	,			Interval Between Onset and Death WEEKS
Medical		disease or condition resulting in death)	n	a	(or as a consec		. V L							_	WEEKS
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that inned b	by P	Part II. Other signif	icant conditio	ns contributing to	death but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. D	id tobac	co use contr	ibute to th	e cause of death?
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Phys r this eral di	e :	1 Yes 2x 27. Manner of Death	X ^{No}	28a. Date	Inpatient 2 Le of injury	ER/Outpatie		8c. Injury	4 ∐ N	ursing Ho			e XX Othe		Assisted Living
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or Atter after des Director in by th	Certificate:	3 Suicide 4 Homicide	6 Could r determi	ot be 28e. Plac	e of Injury - At h ling, etc. <i>(Sp</i> eci		reet, factor	, office				n (Street Town, St		er or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier 1. (Check 2	XXCertifying	Physician: To the	best of my know	vledge, death	occurred a	t the time	e, date and	l place, a	nd due to th	e cause(s) and mann	er as state	ed. use(s) and manner stated
the i	Me	only one) 3	Certifying	Nurse Practitione			e, death occ	urred at t	he time, da			to the ca	use(s) and m	nanner as s	tated.
5 × 6 %		29b. Signature and	DA A	1m A			290		number 2332				Date signed		27, 2012
10m		30. Name and addre	ess of person w	ho completed car	ise of death (Ite	m 23a) (Type	Print)				***		TEDRU	TIL 2	./, 2012
1 04.		SURESH K			984 GEO			280,	SILV	JER S	SPRING	, MI) 2	0902	
Stat	е	31. Date filed (Mont			Registrar's Sign		Kel.								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1345 M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Alice - Ronelda Year 2012 Physician/ Mariano Charlend Forwary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chesapoake Bel Air Medical Harton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. **Director** 1 □ M 2 🕱 F OH 19:30 17 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 Park Hagnts Avenue, USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Coppillege 1 State life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Executive Administrative 12th grade Year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles R. Jackson Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 4003 Bancroff Road Baltimore MD 21215 item 27 rme Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Department of Important: If it any injury or conce. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 12012 Laurel, MD Maryland Nationa 4 ☐ Donation 5 ☐ Other (Specify) Vaugn C. Greenefunoral services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugh-C. Randallstown MD 21133 coad Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Sevene pneumonia attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? performe 1 Yes 2 No 1 Yes 2 No m86038995 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No __ Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 asin Chare D63420 February 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) kharal 500 upper Chesapeake Dr, Bel Air, MD 21014 Registrar

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Director

Completed by Funeral

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Examine

Completed by Physician/Medical

Certificate: To Be

Medical

29a. Certifier (Check

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29b. Signature and title of certifier

Physician/

Medical

Examiner

Funeral Director

For		State of	iviaryiai					and iv	ientai myg	iene		
State Registrar				C	ertifica	ate of L	Death		R	eg. No. 🤈	012	05888
1. Decedent's Name	e (First, Middle, La	,							Date of Deat Month		Vear	3. Time of Death
		E. Mill							Februar	y 26,	2012	6:30 p M
4a. Facility Name (if			er)		4b. C	ity, Town, or	r Location	of Death		4c. Cou	inty of Death	
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214-24-5 Usual Residence of	787	1 M 2 X F	Age (In yrs.	Yrs.	Month		Hours	Min.	8. Date of Birth (Month, Day, Oct 12	Year) 1928	9. Birth Cour Ma	place (State or Foreign htry) aryland
0a. State	10b. County		10c. Ci	ty, Town or	Location							10d. Inside City Limits
MD	 Balti	more		Rei	ister	stown						1 Yes 2 X No
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Marital Status		12. Was Decede		S. 13					cify Yes or No-	14. [Race - Americ	can Indian,
1 Never Marr	ied 2 🗆 Married					pecify Cuba			Rican, etc.)		Black, White,	
3 🔀 Widowed	4 Divorced	If Yes, Give Year or Date	S.		1 ∐ Yes	2 K No	Specify	/:		Spe	cify: V/H	ITE
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7. Father's Name (I									(First, Middle, N		ame)	
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'		Removal from S		Place of Dis cemetery, cr			e)				on - City or Ti	
	5 Other (Spec	"	Ca	rroll				2/28	<u> </u>			Maryland
1. Signature of Fur	neral Service Licer	nsee M	enk	1111		and Addres		, -	1824 Rei Reiste			Road 21136
23a. Part 1. Ente t	he disease, or con	nplications that cau	sed the dear	th. Do not e	nter the m	ode of dyin	g, such as	s cardiac o	r respiratory arre	st,		Approximate
Immediate Cause (I	Final	De	h:lix	1/							Į.	Interval Between Onset and Death
resulting in death)		a. Due to (or	as a conseq	uence of):							-	MON745
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F FEMALE: 23b. Was decedent		23c. If yes, outco		ancy						23d.	Date of deliv	'erv
in the past 12 r	months?	1 ∐ Live Bii 4 ∏ Pregna	nt at time of		☐ Ectop	ic pregnanc (specify)	;y				Month	Day Year
9 Unknown		9 ∐ Unknov	vn									
art II. Other signifi	icant conditions	contributing to dea	th but not res	sulting in the	underlyin	g cause giv	en in Part	t I.	23e. Did tob	acco use co	ontribute to t	he cause of death?
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5. Was case referre	ed to medical					00 5	(2	-41- (0)	1 L Yes 2	740		2 No
examiner?	No	Hospital:				Othe	or.	ath (Check				
7. Manner of Death		1 L In	oatient 2	ER/Outpati 28b. Time		DOA 28c. Injury	4 L N	lursing Hor)
1 Natural	5 Pending	(Month,	Day, Year)	injury		work	≀at ? Yes 2 □		8d. Describe ho	w injury occ	urred	
2 Accident 3 Suicide	Investigation 6 Could not I	be 290 Place of	Injune At 1			ļ	ies Z L		206 1 - " -			10-11
4 Homicide	determined	 I Zoe. Place of 	Injury - At he	ome, tarm, s	ireet, fact	ory, office		1.2	rst Location (Str	eet and Nur	nber or Rura.	l Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Towson MO 21204

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Du

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Black Jason 6701 MO 31. Date filed (Month, Day, Year)

MO

32. Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2009)

32. Registrar's Signatur

4

Please Type or Print in Black Indelible Ink. Ensure Alt-Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle 1 ast) 2. Date of Death Physician/ February 2012 LaForeste Murchison 7:50 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Days Hours Director 242-58-5460 1 🗆 M 2 🖾 F 4-12-1939 North Carolina 72 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. District Heights 1 XYes 2 No 10g. Citizen of What Country? Completed by Funeral 6212 District Heights Parkway 20747 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Nurse Private Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Menta of Health and Menta of item 27 is marked ir other traumatic e Daniel Windsor Elizabeth Sheppard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207476212 District Heights Pkwy., District Heights, Md. Barber - Daughter Sandra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot once, cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 02-26-2012 Greenville, N.C. 4 ☐ Donation 5 ☐ Other (Specify) Homestead Cemetery gnature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYELARDIAL INFARCTION disease or condition resulting in death) MINUTES Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical requires that the death certificate be P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death the 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si lirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law performed 2 1 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 400 Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 TER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After a completely filled in the complete Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the beg my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00068207 ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MPUL Kel1A MD 13 SIMOSTE 31. Date filed (Month, Day, FEB 2 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 19, 2012 8:49 PM Cecille I. Morse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel 9008 Eastbourne Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 554-44-5063 1 □ M 2**XX**F **Director** 1921 China uly 12, permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norfified one. 10d. Inside City Limits 10c. Cify. Town or Location Director 1 X Yes 2 No Prince George's Laurel Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 20708 9008 Eastbourne Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alice Gon Simon John Betines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 79 Delaware Avenue Stirling, NJ 07980 John Betines/ Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemeters, crematory or other place)
Arijngton
tional temetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/6/2012 Arlington, VA Nationa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 101 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Recurrent Pleural Effusion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Breast Cancer 1 ☐ Yes 2 Ϊ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of Renal Cell Carcinoma 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No death? certificate l 1 Yes 2 No s after death.

Director: After this certification by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 2 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 🗌 Yes 2 🗌 No 5 Pending Accident Investigation within 24 hours after dex To the Funeral Director completely filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21 2 CN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2480 Llewellyn Avenue Fort Meade, MD 20755 M.D. Patricia Ayres,

State Registrar 31. Date filed (Month, Day, Year) FEB 2 8 2012

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G924, 2/28/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Malcom Month Physician/ fearl 3:45A 2012 February Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Funeral Hours Min. (Month, Day, Year) Country) **Director** 069-16-5899 1 M 2 X F 89 07/03/1922 NY Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 ဳ No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT WILSON LANE 21208 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【▼ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 9 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 HOMEMAKER 2 should be filed with h and Mental Hygien 7 is marked other th OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MORRIS BROWN IDA BERNSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is STEPHEN MALCOM / SON 300 SALONY DRIVE, #102, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 26 26 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State $02/\frac{16}{2012}$ 4 ☐ Donation 5 ☐ Other (Specify) MT LEBANON CEMETERY ADELPHI, MD 21. Signature of Funeral Service Lice yee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final END-Stage Parkinsons Ph.sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter uncertaining Cause (Disease or injury Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown page 2 should I Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Tother (Specify) Hospital 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapalne M.O 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smin Av 5203 Baltimore MD 2120 9 s. Rajapakse, M.P 31. Date filed (Month, Day, Year) FEB 2 8 2012 32. Registra Signal

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5 Year USER 01: 25A M **Physician** 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10M 20F 01/19/1931 81 Director NY 086-22-6401 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 TYYes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be n 7121 PARK HEIGHTS AVENUE, #406 21215 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items; any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER STATE HIGHWAY ADMIN. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ LOUIS MUSER PAULINE BINDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7121 PARK HEIGHTS AVE., #406, GERALDINE MUSER / WIFE BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 02/27/2012 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service W 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** KECURRENT PNEUMONIA /Medical Due to (or as a consequence of): Examiner YSPHACIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine SEVERE DEBIL 17 burial-tran Due to (or as a consequence of): NEUROPATHY IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ KNEE JOINT CHRONIC 1 Yes 2 No 3 Probably 4 thknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death

Director: within 24 hours aft To the Funeral DI completely filled in

State

Registrar

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

PHYSICIAN

00064533

25/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERIATRIC 2434 W. BEWEDERE AVE BATTIMORE MS 21215 BABATUNDE AJANI MI

31. Date filed (Month, Day, Year) FEB 2 8 2012

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items
State of Maryland / Department of Health and Mental Hygiene
28b,d per me,g925,03/27/2012dhb
Certificate of Death

Reg. No. For State Registrar 2. Date of Death Physician/ Medical give street and Examiner If Under If Unde g, Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 266-55-8118 **Director** 1 X M 2 □ F June 13,1973 38 Florida or 28a-f show 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Baltimore Windsor Mill 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Heraldry Court 21244 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian ori Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie James Nelson Jacqueline Lomax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Lomax: Mother 1744 South Park Avenue, Titusville, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation, Inc. 2-24-12 Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Jac Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day 28b. Time of :45pm 27. Manner of Death 28d. Describe how injury occurred Subject driver 28c. Injury at eral Director: After filled in by the funer 5 \square Pending Natural 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number SUV City or Town, State) ROLLING RD AND 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direc DOGWOOD 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗵 Certifying Numse Practitioner: To the best of my knowledge, Seath Contined at the time, date and place, and due to the cause(s) and mainer as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-201

31. Date filed (Month, Day, Year)

FEB 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) FEBRUARY 24,2012 Physician/ MARGARET M. NOWAKOWSKI 8:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21236 BALTO. 8820 BLAIRWOOD COURT APT.T1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours Director 220-12-2878 1 🗆 M 2 🗶 F 86 FEBRUARY 1,1926 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD. 28a-f NOTTINGHAM BALTO. 1 🗌 Yes 2 🗶 No 10e. Street and Number ms 23a or must be r ō 10f. Zip Code 10g, Citizen of What Country? Funeral 8820 BLAIRWOOD COURT USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. the Medical Examiner Black, White, 9 þ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 □ Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) DEPARTMENT STORE 9TH SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! 2 HELEN CIGANEK JOSEPH ZEMANSKI traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau KAREN ATALLAH DTR. WEST LAFAYETTE, INDIANA 47906 3400 ELKHART STREET saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS 2-27-2012 BALTO.MD. Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, 9705 BELAIR ROAD NOTTINGHAM, MD 21236, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Dire to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 🔲 Yes s after death.
I Director: Aff 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

(Check

only one) 29b. Signature and Mu

31. Date filed (Month, Day, Year)

of certifier

FEB

8

(Type, Print)

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05896 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Ruby Landora Oliver February 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day,) June 26, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Min **Director** 89 Maryland 215-18-8430 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Harford Perryman 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or Funeral 1602 Johnson Lane USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annie Laura Miller Irvin Henry Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai 1940 Park Beach Drive, Aberdeen, Maryland 21001 George F. Oliver / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/25/2012 Bel Air, Maryland Svcs, LLC 21. Signature of Juneral Service Licer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications for transfer to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has perform 1 Yes 2 No Yes Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10068014 02/23/1 NASRIN 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 501 SOUTH UNION AV

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2012

2350

32. Registrar's Signature

			_ FOI	Maryland / Dep			lental Hygie	ene		
			State Registrar	Ce	rtificate of Dea	ath		g. No. 2	12	05897
	Physicia Medic		Decedent's Name (First, Middle, Last) ELLA	PHELPS			2. Date of Death FEBRUAR	Y Day 26 2	2012	3. Time of Death 4:40 A M
}	Examin		4a. Facility Name (if not institution, give street and number 1209 FALCONETT COURT	er)	4b. City, Town, or Loc UPPER MA			4c. County		ORGE'S
	Funeral	1		Age (In yrs. last birthday)	If Under 1 Year If I	Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
L	Director		250-86-6840 1 ☐ M 2 🗓 F Usual Residence of Decedent	63 Yrs.	Months Days He		(Month, Day, Y			H CAROLINA
	and show fat	'n	10a. State 10b. County	10c. City, Town or Lo	cation		<u>.</u>		10	Od. Inside City Limits
	Maryli 28a-f otifiec	Director	MD PRINCE GEORGE'S	UPPER MA	ARLBORO					1 Yes 2 No
	th the 3a or t be n		10e. Street and Number		10f. Zip Code			g. Citizen of V	Vhat Count	ry?
	ath wi	Funeral	1209 FALCONETT COURT 11. Marital Status 12. Was Deceded	ent Ever in U.S. 13.	20774 Was Decedent of Hispar	nic Origin? (Spe		SA 14 Bace	e - America	an Indian
13-0030	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 X Married 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 1 If Yes, Give Year or Date	es? L XI No	lf Yes, specify Cuban, M 1 □ Yes 2 🌠 No S	lexican, Puerto I	Rican, etc.)		k, White, e	tc.
2	2 hour	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during		ng 1	6b. Kind of Bu	ısiness/Ind	ustry
7	ithin 7 ene. • than the Me	Completed	Elementary/Secondary (0-12) College (1-4		O NOT use retired) NISTRATIVE	ASSISTA	NT	GOVE	RNMEN	Т
שמ	e filed w ntal Hygi ed other event, i	To Be	17. Father's Name (First, Middle, Last) LAWRENCE CHARLES WHITE			. Mother's Name	e (First, Middle, Ma	iden Surname)	
2	ould by market market		19a. Informant's Name/Relationship (Type, Print)	19h Maili	ng Address (Street and I			ity or Town S	tate. Zip Ci	ode)
Z N	d 2 sh alth ar 1 27 is er trau		JOHN WHITE/SON		FALCONETT					
ore,	of He If item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Dispersion	osition (Name of matory or other place)	С	Date 2	0c. Location -	City or Tov	wn, State
baitimor	t. Page tment rtant: ijury c		4 ☐ Donation 5 ☐ Other (Specify)	RESHRREC	TION CEMETE	ER¥3/2/2		LINTON		
0	permit Depar Impor any in		21. Signature of Funeral Service Licensee	7	2. Name and Address of	Facility J. ER ROAD	HYATTSVI	LLE,MA	RYLAN	ID 20785
	a three-say		23a. Part 1. Enter the disease, pr complications that car shock, or heart failure. List only one cause on each Immediate Cause (Final	used the death. Do not ent	er the mode of dying, su	uch as cardiac o	r respiratory arrest	t,		Approximate Interval Between Onset and Death
- 4	Medical Examiner		disease or condition resulting in death) a. Due to (or	as a c in equence of):	>				Y	ears
		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	as a consequence oi).						
	scuted and -transit	xami	Cause (Disease or injury that initiated events c.	as a consequence of):						
00	cate be executed physician and the burial-transit	dical Examiner	d.							
00/00	rtificat ling ph	(0)	IF FEMALE:	ome of pregnancy						
DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	in the past 12 months?	rth 2 Fetal death 3 I int at time of death 5 I	Ectopic pregnancy Other (specify)			23d. Dat	te of delive nth	Pry Day Year
s, r.o	ires that the signed by Id be detail		Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given i	in Part I.				e cause of death?
Vital Records,	aw requias beer	Completed by					24a. Was an autopsy	1	orior to con	psy findings available inpletion of cause of
Te	i: The licate h						perform		death?	2 🗀 No
II.a	siciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital:	patient 2 ER/Outpatie	Other	of Death (Check	r <i>only one)</i> me 5፟፟፟ Sesiden	ce 6 Othe	r (Spacifil)	
10 0	nding Phy th. : After this e funeral c		27. Manner of Death 28a. Date of		f 28c. Injury at work?		28d. Describe how			
DIVISION OF	il or Atter after dea Director d in by th	Certificate:	3 Suicide 6 Could not be 28e. Place of	f Injury - At home, farm, st , etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
-	e Hospita 124 hours e Funeral letely fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner: 1	of examination and/or inves	stigation, in my opinion, d	death occurred at	the time, date and	place, and due	e to the cau	use(s) and manner stated.
4	To th withir To th comp	2	29b. Signature and title of continue with the continue of continue of continue of continue of the continue of	,	29c. License nur 025	mber		d. Date signed	(Month, E	Day, Year)
	100h		30. Name and address of person who completed cause	of death (Item 23a) (Type, 200 BASIL C	Print)	LARGO	MD 2	0774	00.	
	Stat Registra			gistrar's Signature	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0.2 Paige Gloria Helen 2012 10:00aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min 213**-**32-0365 74 **Director** 1 □ M 2X F 30 37 10 MD Usual Residence of Deced show 10b County 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f NA MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral with 1 items 23a 5 Sprigg 21207 U.S.A. 10:00 a.m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceuent L. Armed Forces? ⁴ ☐ Yes 2 X No Black, White, etc. ō þ 1X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. Specify: Black "natural", Completed 3 UVidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 2th grade 2yrd Secretary Social Security Adm. 2012 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Catherine Boyce Leroy Paige usge 1 and 2 st. uspartment of Health an Important; If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shanika Lofton-Grandddaughtler 5 Sprigg Ct, Baltimore, Md 21207 Baltimore, FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Memorial 3/1/2012 Woodlawn, Md 22. Name and Address of Facility Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year Pregnant at time of death signed by the a GLORIA PAIGE 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred X Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical

To the Hospital or Attending Physician: 124 hours after www.ie Funeral Director: Aft Tpletely: within 2 To the I

51

State

Registrar

29a. Certifier

(Check

only one) Signature

JACK IE

Date filed (Month, Day, Year)

JONES,

FEB 28

CRNP

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

s of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM

MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 22 Steven Bruce Peter 2012 07:35pM FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birtl 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F (Month Day, Year) 1 184-42-9810 Pennsylvania **Director** 60 Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 □ No PA Berks Kutztown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 37 Rosecrest Drive 19530 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. b 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ Research Chemist Chemistry permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bruce Peter Dorothy Adams Maryi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryan Peter / Son 23 Krick Avenue, Sinking Spring, PA 19608 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/27/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events use as the burial-trar been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No Yes filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) iner? Other: 2 No Yes Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: Ma ner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signat signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) Charles ST State Registrar

DHMH 17 Rev 06-2011

Guy Randall		1- For State Registrar	Sta	ite of Maryl		partment c <i>ertificate</i> o			l Mental I		Reg. No. 20	12 0590		
Physicia Medical Examin	in/	Decedent's Nam Gu	-	,Last)	Rand	lall			<u> </u>	2. Oate of De Month		3. Time of Death 1155 hrs		
		4a. Fecility Name (if not institution	, give street and n					ocation of Dea		4c. County of	Death		
	щ	University F			I 2 A (1	last blate days	Baltir		Terranon	- lo paració		IA		
Funeral Director		5. Social Security N	2908	5.Sex 1. ∑X M 2. F	7. Age (in yrs	s. last birthday) Yr	Month	der 1 Year hs Days	If Under 24H Hours M	in. 06-2	1	9. Birthplace (State or Foreign Country]M ☐		
kua	ŀ	Usual Residence of 10a. State	f Decedent 10b. County		10c. Ci	ity, Town or Loca	ition					10d. Inside City Limits		
I E	۲	MD	NA	1	В	altimo	re					1 X Yes 2 No		
Maryla 28a-f	Director	10e. Street and Nu	mber				10f. Zip	Code			10g. Citizen of Wha	at Country?		
th the 23a or notifie			wynns	Falls I			<u>L</u>		216		USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Marri		ried Armed F	2X No	lf.	Yes, speci	ify Cuban,	Mexican, Puer	Specify Yes or N to Rican, etc.)	White,	American Indian, Black, etc. African		
rs after	à	3 Widowed 15. Oecedent's Ed		rced If Yes, Give Ye or Dates:		1 L		Occupation	specify: on (Give kind o	f work done	Specify: A	American		
72 hour	eted	Elementary/Seco			1-4 or 5+)				DO NOT use n		TOD. Killd of Busi	ness/industry		
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene, n 27 is marked other than numatic event, the Medical		17. Father's Name						18	8.Mother's Nar		Maiden Surname)			
212 uld be Menta mark	lo Be	Bradf 19a. Informant's Na			stronq	19b. Mailin	g Address	s (Street	Mar and Number o	y Ala r Rural Route Nu	ice Ra Imber, City or Town,	Randall City or Town, State, Zip Code)		
MD 12 sho th and a 27 is		Moreen .		ong-Sis		2024	4 Sw	anse	a Roa		imore.MD			
of Heal		20a. Method of Dis 1 K Burial 2		3 Removal f		o. Place of Dispo crematory or o	sition (Na	me of ceme	etery,	Date	20c. Location - 0	City or Town, State		
Baltimore, permit. Pages I as Department of He Deportant: If ite injury or other tr	Į.	4 Oonation 5	Other Spe	cify:		ing Mer				-01-12		.1stown, MD		
Ball permit Depart Impor	-1	21. Signature of Funeral Service Wense 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore.												
Physician					caused the dea	th. Do not enter	the mode	of dying, s	LMOY auch as cardiad	or respiratory ar	Baltimo rest, shock, or hear	t Approximate Interval Between Onset and		
/Medical Examiner	1	failure. List only one cause on sch line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):												
		Sequentially list co		b										
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):												
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60, e be exe ysician g	UNPENDED AMENDED													
876(ifficate		IF FEMALE: 23b. Was decedent		23c. If yes,	outcome of pre		etal death	3	Ectopic preg	nancv	23d. Date of do Month	elivery Day Year		
Sox 6876 feath certificate e attending phy for use as the l	sicia	past 12 months		4 Pregi	nant at time of	dooth -	ther (Spe					,		
b. Bc the dea	Physician/N	Part II. Other signi		9 Unkn		t resulting in the	underlying	cause giv	ven in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?		
P.C.	2			_		· ·	, ,			1Ye	es 2 🗸 No 3	Probably 4 Unknown		
rds, requir	ete				-					24a. Was		ere autopsy findings available or to completion of cause of		
Peco The law ate has	24a. Was an autopsy prior to compare the state of the st									ath?				
Temporary Temp														
f Vid	ပ		2 No	Hospital: 1 28a. Date		✓ ER/Outpatient 28b. Time of		OOA O		ing Home 5	Residence 6 how injury occurred	Other:		
nding th.	티	1 Natural	5 Pendin	FOUNT	Day,Year)	FOUND:	ingury [s 2 Volk?	Subject sho		1		
/iSiC r Atte rer dea irector	ficat	2 Accident 3 Suicide	6 Could	28e Plac		1125 hrs home, farm, stre	et, factory	2000				or Rural Route Number, City		
Dital of filled i	Certification:	4 Momicide	determ		Local Str	eet				or Town, 9 2200 North F	State) ulton Street, Balti	imore , MD		
	ल	29a. Certifier 1 (Check only one) 2		iner:On the basis	of examination	-			•		se(s) and manner as and place, and due			
F. & F. 8	and manner stated. 29b. Signature and title of certifier 29d. Date signe								29d. Date signed	(Month, Day, Year)				
		Ca	Lae 9	Hall	ad			O.C.M	l.E.		February 24,	, 2012		
- 1		30. Name and addre			-		timore '	Street =	Raltimore M	AD 21223				
Sta	ate	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar's Signature												
Registr	rar	LER %	3 8 2012	Denne	J. J.	A ar Rod								

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		For	State of M	laryland					nd Me	ntal Hyg	giene	2012	05001
		Registrar 1. Decedent's Name (First, Middle, i	(cot)		Cei	rtificate	OT DE	eatn	Ta	Date of Dea	Reg. No.	<u> </u>	3. Time of Death
Physicia	n/								2	Month 2/2		1 2 Year	3:45 A M
Medic		Carl Henry Rau 4a. Facility Name (if not institution, g		Sr.		4b. City.	Town, or L	ocation of [Death	212		County of Death	
Examin	G1	Ridge Overlook		Livin	g	1		inste				Carrol	.1
Funeral		5. Social Security Number 6		ge (In yrs. la		If Under Months		If Under 24		Date of Birt			hplace (State or Foreign intry)
Director		218-03-1839	1 X M 2 □ F	98	Yrs.					7/28/			MD
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limits
laryla 3a-f s ified	Director	MD Carro	011	,	Woodb:	ine							1 🗌 Yes 2 ื No
the N or 28		10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	untry?
s 23a	Funeral	6951 John Picl					2179					USA	
death item		11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Deced If Yes, spec	ent of His ify Cuban	panic Origin , Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)	1	 Race - Amer Black, White 	
after al", or xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced		1938 -	44	1 🗌 Yes	2 X] No	Specify:			S	Specify: Wh	ite
hours natura ical E	Completed	15. Decedent	's Education		16a Dece	dent's Usua	I Occupat	tion	- f d		16b. Kin	d of Business/	Industry
e. Med	dmc	(Specify only highes Elementary/Secondary (0-12)	College (1-4 or	5+)	life. L	OO NOT use	retired)	iring most o	oi working				_
e fled within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12			Po	lice						timore	County
e filec ntal H ed otl	To Be	17. Father's Name (First, Middle, La								First, Middle, enzel	Maiden S	urname)	
should be and Ment is marker aumatic		Carl Emory Rat 19a. Informant's Name/Relationshi			10b Mail	ing Addross	(Street as				r City or T	Town, State, Zip	Code)
~ ~ ~ ~ ~		Frank Rauscher											, MD 21724
permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other trong.		20a. Method of Disposition			lace of Disp emetery, cre	osition (Nar	ne of		Dat			cation - City or	
Page ant: If ury or		1 → Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp			rowed				3/2/2	012	Wo	odbine,	MD
permit. I Departin Importa any inju		21. Signature of Funeral Service	enseenn		2	2 Burr	fêreç	of Facility	Fune	ral Ho	me &	Cremat	ory, P.A.
1 88E 8 5		John Al	eller									field,	MD 21784
		23a. Part 1. Enter the disease, or c shock, or heart failure. List or	ily one cause on each lir	ne e									Approximate Interval Between Onset and Death
Physician/		Immediate Cause (Final disease or condition resulting in death)	Athen			10 (ardi	Vasi	culo	or 1	11750	710	Onoce and Board
Medical Examiner		resulting in deathy	Due to (or as	a consequ	ence of):								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a consequ	ence oi).		_						
rted d ansit	amil	cause. Enter Underlying Cause (Disease or injury that initiated events											
te be executed hysician and he burial-transit	ical Examiner	resulting in death) Last	Due to (or as	a consequ	ence of):								
te be hysici	dica	\ \	d	 					· · · ·				
irtifica ling p	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	ncv							23d. Date of de	livory
ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth	2 Feta	l death 3	☐ Ectopic ☐ Other (s		у			10.2	Month	Day Year
the described	ysi	1 Yes 2 No 9 Unknown	g 🗌 Unknowr										
requires that the death certificate I been signed by the attending physishouid be detached for use as the	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the	underlying	cause give	en in Part I.					the cause of death?
duires	ed									1 🗆	Yes 2	□No 3□P	robably 4 Unknown
aw require as been si	Completed									24a. Was auto	psy	prior to	topsy findings available completion of cause of
The la	Con										ormed? 2 24 0	death?	s 2 No
rsician: rsician: s certific	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ace of Death				_	Act. Living
Physi this o	2	1 Yes 2 No	1 1npa	itient 2 🗆	ER/Outpation 28b. Time (OA Dilio 28c. Injury	4 ∟ Nur		e 5 Resi d. Describe I		Other (Spec	cify)
ding Plub.	cate	1 Avatural 5 Pending 2 Accident Investig	(Month, D	lay, Year)	injury	М	work?	? Yes 2 □ 1	i		,		
Attendir frer death. irector: Af in by the fu	Certificate:	3 Suicide 6 Could r	ot be 28e. Place of Ir	njury - At ho etc. (Specify	me, farm, s	treet, factor	y, office		28	If. Location (ıral Route Number,
ris after or all Dir													
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check A Medical F	Physician: To the best caminer: On the basis of	examination	and/or inve	estigation, in	my opinio	n. death occ	curred at th	ne time, date :	and place,	and due to the	cause(s) and manner stated.
o the	Ž	only one) 3 L Cartifying 29b. Signature and title of cartifier	Nurse Practitioner: To	the best of n	ny knowledg		c. License		e and place	e, and due to		e sjgned (Mont	
H S H Ö		100					043	3725	5		2	1271	112
MIM		30. Name and address of person v	/ho completed cause of	death (Item	23a) (Type,	Print)	D	1	1 4	vest	m i'	رعلء	MD
U" "		TARIG MI	+ Umo op	19	FI	dye		000	(-31		1118	21151
Sta Registr		31. Date filed (Month, Day, Year)	2012 32. Jegis	trar's Signa	d. A	back	/						

DHMH 17 Rev 06-2011

			For State Registrar		State o	f Marylar		artment of tificate of		and Menta		ene 1. No. 201	2 05902
	Dhysici	an/	1. Decedent's Name (Fin	rst, Middle, I	Last)		·			2. Dat	te of Death		3. Time of Death
-	Physicia Medi		LOIS		Kuss					FEF	Maus	Free, 2	512 1247 PM
	Exami	ner	4a. Facility Name (if not	•		ber)		4b. City, Town,			0	4c. County of D	
	Funeral	-	Good Sc 5. Social Security Numb	er 6		7. Age (In yrs. i	last hirthday)	If Under 1 Yea	r If Under		-f Dist	N/A	
	Funeral Director		217-24-264	- 1	1 □ M 2 4□ F	84		Months Days			te of Birth C11 13	9. 1927 Ma	Birthplace (State or Foreign Country) LYLand
	T ow	١.	Usual Residence of Dec							1 1-1-		///	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	MD		imore	10c. Cit	ty, Town or Lo	Parkville					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the s 23a or lust be n	eral D	10e. Street and Number 2314 Pu		ill Avenu	ie		10f. Zip Code	1234		10g	. Citizen of What	
	death item ner m		11. Marital Status		12. Was Deced	dent Ever in U.S	S. 13. V	Vas Decedent of	Hispanic Orig	gin? (Specify Yes n, Puerto Rican, e	or No-	14. Race - A	merican Indian,
36	after al", or Examin	d by	1 ☐ Never Married 3 ☐ Widowed 4 ☐		d 1 ☐ Yes If Yes, Give	2 🔼 No		Yes 2 X N			10.)	Black, W Specify:	hite, etc. white
9-0	hours natur lical E	lete	15	i. Decedent's		tes.	16a, Deced	lent's Usual Occi	upation		16		
21215-0036	ed within 72 Hygiene. other than " ent, the Med	Completed	(Specify of Specify of		grade completed) College (1-	4 or 5+)	(Give I	and of work done	during most	t of working		b. Kind of Busine K-Mart	ss industry
Maryland	should be filed vand Mental Hyg ris marked oth raumatic event,	To Be	17. Father's Name (First,		t)					er's Name <i>(First, I</i>	Middle, Maid	den Surname)	-
	2 ± 2 +	30	19a. Informant's Name/I Anthony Ru	Relationship			19b. Mailin	g Address (Stree Taylor	t and Numbe Avenue	er or Rural Route Parkvi	Number, Cit 11e , M a	y or Town, State, aryland	Zip Code) 21234
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Dispositi 1 🛎 Burial 2 🗆 Ci 4 🗆 Donation 5 🗆	remation 3		20b. F	Place of Disportance	sition (Name of Patony prother pla Pardens	ace) F	Date 126, 20		c. Location - City	
Baltii	permit. Page Department Important: I any injury o	30	21. Signature of Funeral			Memo						emation S Maryland	
			23a. Part 1. Enter the di	sease, or co	mplications that ca	aused the deat						Maryland	
and the same	Physician/ Medical		shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	ure. List only	one cause on eac	Deme	nta				,,		Approximate Interval Between Onset and Death
-	Examiner	-le	Sequentially list condition	ons,	b. —	as a consequ	e F	balla	to al				
	cuted ind transit	Examiner	if an leading to immed cause. Enter Underlying Cause (Disease or iinjun that initiated events		c	>u Sp	nea						
09	be executed sician and burial-transi	dical E	resulting in death) Last	Ų	Due to (o	r as a consequ	ience of):						
376	ficate g phys as the	Vedi			_ d	-							
. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			irth 2 🗌 Feta ant at time of d	I death 3 🗌	Ectopic pregnar Other (specify)	псу			23d. Date of o	delivery Day Year
, P.O.	res that the signed by 1 d be detach	by	Part II. Other significant	conditions	contributing to dea	ath but not res	ulting in the ur	derlying cause g	iven in Part I.	. 23e			to the cause of death?
ords	require been si should	letec								240	1 ∐ Yes a. Was an		Probably 4 Dunknown
Division of Vital Records,	sician: The law is certificate has k	Completed	05 W								autopsy performed Yes 2	prior to death'	completion of cause of
/ita	siciar s certif	To Be	25. Was case referred to examiner? 1 Yes 2 V	medical	Hospital:			Ott	ner.	h (Check only one			
n of \	ding Physician: h. After this certific funeral director,	ate: T	27. Mann Death 1 Natural 5	Pending	28a. Date of (Month	patient 2 finjury , <i>Day, Year)</i>	28b. Time of injury	28c. Inju wor	ry at k?	28d. Des		e 6 Other (Spenjury occurred	ecify)
visio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not determined	be 28e. Place o	f Injury - At ho g, etc. (Specify)		M 1 L	Yes 2□I	28f. Loca	ation (Street or Town, Sta		ural Route Number,
۵	lospital of the hours a uneral Ded filled i	Medical C	29a. Certifier 1 C	ertifying Ph	ysician: To the bes	st of my knowle	edge, death o	ccured at the time	e, date and p	place, and due to	the cause(s)	and manner as s	stated.
	To the H within 24 To the F complete		only one 3 C	ertifying Nu	rise Practioner: T	th, L. E. Tiny	and/or investige, or	29c. Licens	se number	curred at the time,	date and pla to the east 29d.	ace, and due to the	e cause(s) and manner stated.
	MAG		30. Name and address of	nerson wh	Completed	of closel (14-	220) (5.00 - 5.	1 10	068	994	Fee	brieg	Thue, 2012
	JA.,		Patricia a	inee	ve 56	Of Lo	ch (Lever	BIL	rd. Bu	thm	212	19 39
	Stat Registra	e ır	31. Date filed (Month, Day	8 2012	32. Reg	pistrar's natu	parke					Date signed (More Service)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helena Kobinson 10:31P Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayline Circle Baltimore Uninas Mills Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year III Under 24 Hrs. **Funeral** 8. Date of Birth 057.30.2633 1 □ M 2 🔀 F Months Days Hours **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State must be notified at 10d. Inside City Limits Director Baltimore Mills MD Wings 1 Yes 2 XiNo 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9817 Bayline items 23a Funeral 2117 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any rijury or other traumatic event, the Medical Examin ence. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 College (1-4 or 5+) Elementary/Seconday (0-12) Medical Records Clerk Hospital 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarence Smith Wolferdina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit, Town, State, Zip Code) Bayline Circle Ownas Mill, MD Kabinson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Meadowridge Cemetery 01/242 4 Donation 5 Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Yanam C Greene Funcial Gervos Vaud Randalstown MD 21133 oad 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions To Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit ause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2. No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 6 \square Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R162370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Sacily, Baltimore, MD. 21201 CRNP M MS 22 31. Date filed (Month, Day, Year) State **FER 28** Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1150 PM Alice Rice 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERLARE BALTIMORE Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Min. 57 249-04-1005 1 □ M 💥 F 54 Usual Residence of Deceden 06 24 SC 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 🗆 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 Mareco Ave 21213 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madison David Jr. Alice Lemon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly David-Daughter \$100 Mareco Ave, Baltimore, Md 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 2/28/2012 On-Site Baltimore, Md March F/H West 4300 Wabash Ave, Baltimore, 21215 . Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final HIV/AIDS disease or condition resulting in death) Due to (or as a consequence of) FAILURE - ACINETOBACTER TWOWEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of ALVEOLAR HEMORR HAGE Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performe 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one)

Ph_sician/ Medical Examiner Examine

Physician/

Medical

10a. State

MD

sho

IF FEMALE:

Examiner

Funeral

Director

show

28a-f

ıral", or items 23a o Examiner must be

"natural"

al Hygiene. d other than "natura event, the Medical E

Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event,

notified at

Director

Funeral

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Completed

Be

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with the Maryland

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

the burial-transit nding physician certificate be as been signed by the a should be detached 1 has page 2 Director: After this certificate filled in by the funeral director, Hospital or Attending

Box 68760

P.O.

Division of Vital Records,

hours after

To the I

within 24 hours a

To the Funeral C

completely filled

Physician/Medical

ģ

Completed

Be

Certificate:

Medical

AMBBRILLATION 25. Was case referred to medical

examiner? 27. Manner of Death

1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 4 \square Homicide determined

29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur¶and title of certifier

Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury

work? 1 \sum Yes 2 \sum No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

City or Town, State) Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALTO

Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

333B

AVE

29d. Date signed (Month, Day, Year) 23

28f. Location (Street and Number or Rural Route Number,

me and address of person who completed cause of death (Item 23a) (Type, Print) WATKIN 3330 WILKEN

Year) 31. Date filed (Month,

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 4c, per phy, g924 2-28-12 sm State of Maryland 7 Department of Health and Mental Hygiene 1 = State Amend Items 25,27,28a-f per me 926,04/16/2012dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 Month Physician/ 1407 amsas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Mary land If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 215-44-2237 1 □ M 2 🔀 F **Director** 11-14-1940 Maryland be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 XNo Maryland Harford Churchville 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 3527 Level Road 21028 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ပ္ of Health and Ments fitem 27 is marked rother traumatic e Alfred Ovington Bowman Elma Matilda Elsner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ramsay / Spouse 3527 Level Road, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Rose Hill Svcs, LLC 4 ☐ Donation 5 ☐ Other (Specify) 2-24-2012 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) due to (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undanying Examine Due to (or as a consequence of): 'AL EXAMINER Cause (Disease or injury that initiated events resulting in death) Last PPROVED BY MED the burial-tran Due to (or as a consequence of): CERTIFICATION A attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ☐ Pregnant at time of death☐ Unknown the a Yes 2 No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mjories 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has Astila performed?

Yes 2 No death? After this certificate I 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 2 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 🗶 No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Subject passenger in a car collided with two vehicles.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 74 near Route
200, York Pennsylvania 2 Netural 2 Accident 5 Pending 08/23/2011 3:57 p. M Investigation Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Roadway To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore WOSISOI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Josephine Mary Ridge 10:30a February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carrol1 **Examiner** Carroll Lutheran Village Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 213-26-4896 Director 1 □ M 2 X F MD Sept 13 1914 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Westminster Carrol1 1 ☐ Yes 2 ☐XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 21158 300 St. Luke Circle 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Salvatore Fiorino Giuseppa (maiden name unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10202 Burnside Dr., Ellicott City, MD 21042Mr. William Brooks (son-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 2-29-12 Woodstock, MD 4 ☐ Donation 5 ☐ Other (Specify) Alphonsus Cem. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Onset and Death Immediate Cause (Final Dementio Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Cther (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier D51705 gan wita 02-27-20(2

Registrar DHMH 17 Rev 06-2011

State

Box 68760

Division of Vital Records,

DR. Westminstel.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print A. PANGURLUA . 349 Mal Column

ANIANEMAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician/ Medical Examiner Funeral **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 12

-	For State Registrar		State o	of Marylan		artment of H tificate of D		and M	lental Hy	gier Reg. I	20	12	05907
	1. Decedent's Nam	e (First, Middle	, Last)						2. Date of De	eath		Year	3. Time of Death
	BERTHA		give street and nun		OBBINS				FEBRUA			2012	7:25 P M
	,		SPICE CAR	,		4b. City, Town, or TOWSON		of Death		'	4c. County RΔT	of Death	ਸ਼ੁਸ਼
	5. Social Security N		6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th			place (State or Foreign
	214-12- Usual Residence		1 □ M 2 X F	90	Yrs.	Months Days	riours		08/26/			Couri	MD
	10a. State	10b. County		10c. City	, Town or Loc	cation						1	0d. Inside City Limits
	MD		TIMORE		BALTI	MORE							1 🗆 Yes 2 🛣 No
	10e. Street and Nur					10f. Zip Code				10g.	Citizen of \	What Cour	ntry?
	11. Marital Status	ARK HEI	GHTS AVEN	UE, UNI'		21 Vas Decedent of His	208 spanic Ori	igin? (Spec	cify Yes or No-		USA 14 Bac	e - Americ	an Indian,
١	1 Never Marr	ied 2 🗌 Marr	ied Armed Fo	rces? 2 X No	If	Yes, specify Cubar	i, Mexicar	n, Puerto F	Rican, etc.)		Blac	ck, White,	
	3 X Widowed		If Yes, Giv Year or Da					:		_	Specify:	WH	ITE
		cify only highe	t's Education st grade completed		(Give k	lent's Usual Occupa kind of work done do D NOT use retired)		st of workin	g	16b.	Kind of B	usin e ss/In	dustry
	Elementary/Second 12	ondary (U-12)	College (1	-4 or 5+)		MEMAKER					OWN	HOME	
	17. Father's Name (ast)				18. Moth	er's Name	(First, Middle,	, Maide	n Sumame	∍)	
	EMANUEI 19a. Informant's Na		in (Time Drink)	HURWIT				RAH					DOCK
I			ERG/SON			ig Address <i>(Street a</i> MEADOWSWE							,
ľ	20a. Method of Disp	oosition			lace of Dispos	sition (Name of natory or other place			ate		Location -		
	1 💢 Burial 2 4 🗌 Donation		3 Removal from pecify)	State	•	HEBREW C	1	02/26	5/2012		REIST	rerst	OWN, MD
	21. Signature of Fu	neral Service Li	Muse	\sim		Name and Addres REIST							
1	23a. Part 1. Enter t	he disease, or	complications that only one dayse on ea	caused the death							2 1111	۲۱ و تاد	Approximate
	Immediate Cause (Final	1/0	men l	8/2				DI	ر ا	Jh		Interval Between Onset and Death
	resulting in death)	ì	-	(or as a consequ	ence of):	4	0		3 K	9	9		
	Sequentially list co	nmediate	b. 1	or as a consequ	ence of):	CIMA	٧)		
	cause. Enter Under Cause (Disease or that initiated events	injury	G					SE.	=/ \$	1			
	resulting in death) I	Last	Due to	(or as a consequ	ence of):					Ž.			
			d					· · ·	4-	-			
	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out	come of pregnar	псу	1			Du		23d. Dat	te of delive	erv
	in the past 12 t			Birth 2 Fetal nant at time of d		Ectopic pregnancy Other (specify)	'				Мо		Day Year
ŀ	9 Unknown Part II. Other signif	icant condition			Ilting in the ur	nderlying cause give	en in Part	1	220 Did t	obooo	LIGO CONT	ributo to th	e cause of death?
													pably 4 2 Unknown
									24a. Was		24b. \	Nere autor	osy findings available
									auto perfo	psy ormed? 2 X		orior to con death? 1 🔲 Yes	mpletion of cause of
Ì	25. Was case referre examiner?	ed to medical	Hearth				-	th (Check			110		
-	1 Yes 2 2 27. Manner of Death	No	Hospital:	Inpatient 2 I	ER/Outpatient		4 ∐ Nu		ne 5 🗆 Resi		-		Hospice
	1 Natural 2 Accident	5 Pending Investig	(Mon	th, Day, Year)	injury	28c. Injury work?	aī ′es 2 🔀		8d. Describe h	now inji	dow.		
	3 ☐ Suicide 4 ☐ Homicide	6 Could n	not be	of Injuny - At hor	me form stre	et, factory, office		`	8f. Location (Street a			Route Number, Rd
		-		ASS S		Llving			Towgo	v,	MD	215	36
	(Check 2	Medical Ex	Physician: To the b caminer: On the bas Nurse Practitioner	is of examination	and/or investi	igation, in my opinior	, death oc	ccurred at t	he time, date a	and plac	ce, and due	to the cau	use(s) and manner stated.
l	29b. Signature and	title of certifier	/			29c. License	_			29d. E	ate signed	Month, E	Day, Year)
-	OO Name		N.D. /		00-) 7 =	D007(!				2	23(1)		<u>-</u>
-	30. Name and addre	ess of person w	no completed caus	A A	23a) (Type, Pr	* 41051	Balt	Luel	1M,9	6 0	OA)	4	
	31. Date filed (Monti	h, Day, Year)		egistrar's Signati	ire do	pes .	- ' '				<u> </u>		
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DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 February 2012 Katherine Dorothy Schiaffino 12:44 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 101 North Beaumont Avenue Catonsville Baltimore Social Security Number Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday Birthplace (State or Foreign Country) Months Days Hours **Director** 212-32-0165 1 □ M 2 X 97 Yrs April 21,1914 Maryland Usual Residence of Deced or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tyes 2X No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 101 N. Beaumont Avenue 21228 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes ② No Specify. 3

▼ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Special Checking Processor Banking Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 George Spence Elizabeth Einschultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Linantud, Daughter N. Beaumont Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 03/01/12 Woodlawn, Maryland 21. Signature of Funeral Service Licens Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Energy of the cause (Disease or injury Examine that initiated events Due to (or)s a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Pregnant at time of death Month Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the detached Unknown P.O. n signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 2 Nc 3 Probably 4 Unknown page 2 should been . Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? this certificate | 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: hin 24 hours after death. Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at After 28d. Describe how injury occurred Natural 5 Pending work? Accident 1 Yes 2 No 24 hours after death Funeral Director; Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 7004 Security Boulevard Suite 101 Baltimore, MD 21244 1 31. Date filed (Month, Day, Year, State FEB 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 19 2012 7:42 Charlotte Τ. Schauman Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ma Maison Assisted Living Nottingham Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Months Days (Month, Day, Year) 215-10-3841 **Director** 1 □ M 2 🏋 F 101 Feb. 8, 1911 Maryland Usual Residence of Decedent 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2X No Maryland Baltimore Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8932 21236 Carlisle Avenue United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 🗌 Yes 2 📉 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify White 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Switchboard Operator Dairy Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည other traumatic Ε. Schauman Rosa Schaub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Charlotte Wilson / Niece 8932 Carlisle Ave., Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 02/20/2012 | Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician Physician/Medical certificate be P,O, Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Wo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 No 1 Yes Yes or Attending Physician: the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes Assisted 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Living 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be Accide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2/20/ 037612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Mohamad Alabrash, M.D.

31. Date filed (Month, Day, Year)

5430 Campbell Blvd., White Marsh, MD 21162 (Suite 213)

			For	State	of Maryla	nd / Depa				and M	iental Hy	giene				
			State Registrar			Cer	tificat	e of D	eath			Reg. No. 2	1/2	05910		
	Physicia	n/	1. Decedent's Name (First, Middle, L	*	M-11						Date of De Month	ath Day	Year	3. Time of Death		
	Medic	al .	Glenn Abbott Sp				_				Feb.	27, 201		8:30 A M		
	Examin	er	4a. Facility Name (if not institution, g.	ve street and nur	nber)			Town, or l umbia		of Death		4c. County	of Death C GOME	-17		
	Funeral		Harmony Hall 5. Social Security Number 6.	Sex	7. Age (In yrs.	. last birthday)	If Unde		If Under	24 Hrs.	8. Date of Bir			lace (State or Foreign		
	Director		241-46-8555	1 □ M 2 X F	82	Yrs.	Months	Days	Hours	Min.	Jan. 3	ny, Year)	Coun	Carolina		
	_ %		Usual Residence of Decedent		1											
	ryland -f sh ied af	cto	10a. State 10b. County			City, Town or Loc olumbia	cation						1	0d. Inside City Limits 1 Yes 2 No		
	e Ma r 28a notif	Dire	MD Howard 10e. Street and Number			JIUIIDIA	10f. Zij	Code				10g. Citizen of	What Cour			
	rith th	ra	6336 Cedar Lane					044				USA	Wilat Ooul	iu y :		
	ems ems	Funeral Director	11. Marital Status		edent Ever in U	J.S. 13. V	Vas Dece	dent of His	panic Ori	gin? (Spe	cify Yes or No-	14. Ra	ce - Americ			
ပ္	or it		1 Never Married 2 Married		2 🔀 No			cify Cuban 2 🔀 No			Rican, etc.)		ck, White,			
9	urs af tural" al Exa	Completed by	3 ☐ Widowed 4 🏻 Divorced	If Yes, Given Year or D								Specify	∉ Whi	.te		
5	72 ho "na" r ledica	ple	15. Decedent's (Specify only highest)			rk done du		t of worki	ng	16b. Kind of E	lusiness/In	dustry		
12	ithin ene. r thai	S	Elementary/Secondary (0-12)	College (1	1-4 or 5+)	Teach		e retired)				Educati	on			
Maryland 21215-0036	iled w	Be	17. Father's Name (First, Middle, Las			1			18. Moth	er's Name	e (First, Middle,	Maiden Surnam	aiden Surname)			
ılar	J be f Jenta Irked Itic ev	10	John Harden						Nina	а Јо	Holt					
lan	shoull and l is ma auma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street ar	nd Numbe	er or Rura	l Route Numbe	er, City or Town,	State, Zip (Code)		
≥,	lealth fealth m 27		Frank Springer	son_					/alle			, VT 056				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		n State	. Place of Disport cemetery, cren	natory or o	other place			Date	20c. Location	•			
Iţi	it. Pagirtmer		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Fir	nal Jour		-			9/12	Woodbi	ne, M	1D -		
Ba	permi Depar Impo any ir		21. Signatur of Funeral Aervice Lice	To Old	M01	22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. CLarksville, MD							784			
			23a. Part 1. Enter the bisease, or co	omplications that	caused the de		r the mod	le of dying	, such as	cardiac c	r respiratory a	rest,	VIII	Approximate		
	hysician/		shock, or heart failure. List only Immediate Cause (Final disease or condition		entia									Interval Between Onset and Death		
	Medical		resulting in death)	_ d	(or as a conse	quence of):										
	Examiner	<u>.</u>	Sequentially list conditions,	b. —												
	sit sit	nine	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	equence of):										
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0	ate be executed physician and the burial-transit	dical Examiner	,	d												
3760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	/ledi		d												
Box 687	requires that the death certifica been signed by the attending p should be detached for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome of preg	nancy etal death 3	Ectopic	preanancy	,			23d. D	ate of deliv	′		
Bo	death Te atte ed for	sici	in the past 12 months? 1 ☐ Yes 2 🄀 No		gnant at time o		Other (s					M	onth	Day Year		
P.0.	at the d by th etach	Phy	g ∐ Unknown Part II. Other significant condition:	s contributing to	death but not r	esulting in the u	nderlying	cause give	en in Part	I.	23e Did	tobacco use con	tribute to th	ne cause of death?		
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rds	requir been s	etec	12 - 12								24a. Was			psy findings available		
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Division of Vital Records,	n: The ificate or, pa	ပိ	25. Was case referred to medical	1				26. Pla	ce of Dea	ath (Check	1 \(\superset \text{Yes}\)	2X No	1 Yes	2 L No		
Vita	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2 (☐ ER/Outpatier	nt 3 🗆 🗅	Othe	r			idence 6 🔽 Otl	ner (Specify	Assisted		
of	ng Phy ter thi neral		27. Manner of Death	28a. Date		28b. Time of injury		28c. Injury work?	at			how injury occur		Living		
on	eath. or: Af the fu	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	tion			М		Yes 2 □	No						
Visi	or Att	Serti	4 Homicide determin	28e. Place	e of Injury - At ling, etc. <i>(Spec</i>	home, farm, stre cify)	eet, factor	y, office			28f. Location (City or To	Street and Numi wn, State)	ber or Rura	Route Number,		
	To the Hospital or Attending Physician: "While 24 hours after death as a fifter death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 🛣 Certifying P	hysiciany to the	hest of my kno	wledge death	occurred a	at the time.	date and	d place, a	nd due to the o	ause(s) and mar	ner as stat	ed.		
	e Hos 124 h e Fun	Medical	(Check 2 Medical Example only one) 3 Certifying N	miner. On the ba	sis of examinat	tion and/or invest	tigation, in	my opinior	n, death o	ccurred at	the time, date	and place, and d	ue to the ca	use(s) and manner stated.		
	Voithiir Comp	_	29b. Signature and title of certifier					c. License				29d. Date sign	ed (Month,	Day, Year)		
	Λα , /)	L.	1 ~~	F		D474	147			Februar	y 27,	2012		
	100		30. Name and address of person wh													
			Andrew Lazris (334 Ced	ar Lane	Columb	ia,	MD 21	044				_			
	Sta Registr		31. Date filed (NP EB 298) 20	172 Pery	registral s olgi	fure far	Kal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20Day 20/2ear Physician/ FEB 0900 PM Carol Ann Smelser Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death **Examiner** 4c. County of Death AGNES HOSPITO BACTI MORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8-16-1946 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6. Sex 7. Age (In vrs. last birthday 1 □ M 2 🛣 F 65 Yrs. **Director** Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2XXNo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 5626 Johnnycake Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumating seconds. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Skorupa Ceceial Linton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5626 Johnnycake Road Catonsville, MD 21228 Mary Myers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park Feb27, 2012 Glen Burnie, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death rdio senic Ph_ysi∟ian disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Who 5 Other (specify) Month Day Year Pregnant at time of death by the P.O. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical **Division of Vital** Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P25490 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali DAM AR 1 700 S CATON Baltimore 21228 CATON 31. Date filed (Month Day Registrar's Signatu State 8 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 2012 Physician/ Clare T. Simms February 4:09 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 214-24-2777 84 1 □ M 2**XX**F **Director** July 26,1927 Baltimore, Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important, if items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director Baltimore Parkville 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21234 8710 Avondale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Simms, CLARE Armed Forces? 1 Yes 2 XNo 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Carrie Dietz Raymond Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8710 Avondale Road Parkville, Maryland 21234 Laurence Simms (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Februa 1 X Burial 2 Cremation 3 Removal from State 28, 2012 Parkville, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Auneral Service Lice wars Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 id 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) onsequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 3 Ectopic pregnancy 5 Other (specify) signed by the at d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No page 2 death? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Tyes 1 X Inpatient 2 - ER/Outpatient 3 - DCA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at work? 1 Yes 2 No Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending within 24 hours after death. To the Funeral Director: Af completely filled in by the fu Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Marilyn Simms 2:45 P M February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 26,1932 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours 80 W<u>isconsin</u> Yrs **Director** J<u>an.</u> 398-28-9713 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò an "natural", or items 23a o Medical Examiner must be Funeral 7421 Arrowood Rd. 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Black White, etc. Never Married XX Married þ 2XXNo Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Ekerdt Stella Milford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Raymond A. Simms / Husband 7421 Arrowood Rd., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 02/24/2012 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Rappe Tuneral Failed Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OVARIAN CANCER resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE: /es, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2XXNo Month Day Year signed by the at Id be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, PYODERMA GANGRENOSUM 1 ☐ Yes 2 XXNo 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Ves XIX autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2XXNo 4 XX Jursing Home 5 Pesidence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No XX Natural 5 Pending Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MASTERSON M.D. 6858 OLD DOMINION DR. #104, MCLEAN, VA, 22101

29c. License number

D50534

29d. Date signed (Month, Day, Year)

FEBRUARY 23, 2012

31. Date filed (Month, Day, Year) FEB 2 8 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 27, 2012 Eva Speca 5:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Canton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 97 Maryland 214-14-1841 **Director** 1 □ M 2 🛛 F 7-24-1914 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ms 23a or 21224 Funeral 1300 S. Ellwood Avenue USA er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces 1 Never Married 2 Married Yes 2 X No by Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Proprietor Restuarant 6th Be 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Juliano 17. Father's Name (First, Middle, Last) th and Mental H

27 is marked of
traumatic ever 2 1 and 2 should be of Health and Menta Amadeo Coccia 19a. Informant's Name/Relationship (Type, Print) daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health ar Important: If item 27 is any injury or other trau Vivian Clarke 114 Lyndale Avenue, Nottingham, MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State /2012 cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, MD Oaklawn 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee ^{22. Name and Address of Facility} Joseph N. Zannino 263 S. Conkling St., Baltimore, Zannino Jr. FH imore, MD 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart f Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ teriosclewie Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-transi and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed Porphual Union Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 Yes 2 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ည funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred s after death.

I Director: After the din by the funera Certificate: 1 Natural 5 Pending Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after

To the Funeral Direct

completely filled in by City or Town, State) Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Lieuxel (Secondary) 19667 02-28-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2 this Hylway

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32. Registrar's Signature

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12-01549 Pheobe Spickler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Phoebe Spickler 2. Date of Death Physician/ 3. Time of Death Month Day February 21, 2012 Medical Examiner Phoebe Taber Spickler 1746 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 517 D S. Frederick Avenue #101 Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director 228-04-4162 2 X F 51 Country) Virginia May 1, 1960 1 M Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Montgomery Gaithersburg Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
nent. If item 27 is marked other than "natural", or items 23s or 23s-f shu rother traumatic event, she Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 517 S. Frederick Ave #101D 20877 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: <u>る</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Assistant Manager Hospitality 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) B Howard Carleton Taber Shirley Richelderfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11602 35th Place Beltsville, MD 20705 Barry Spickler / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date permit. Pab.
Department of .

'uportant: If iv 1 Burial 2 Cremation 3 Removal from State crematory or other place) Final Journey Crematory 2/28/12 Woodbine, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licensee Cusa M01651 21029 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a Gabapentin Intoxication Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g926 4-12-12 sm #1, per me, g927 5-7-12 sm X UNPENDED attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 V Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of ✔ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject overdosed on Division 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 1 Yes 2 X No medication fd 2-21-12 fd 5:45 pm Certificat 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 517 D S. Frederick Ave. 101 Gaithersburg, MD. 3 X Suicide Could not be determined Residence Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) ol O.C.M.E February 22, 2012 per 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (MT) EB 2 8 2012 32 Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 25 2012 Physician/ FEBRUARY 8:20 AM STEPHENS LUCILLE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LANDOVER 3305 DODGE PARK ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 229-54-7169 1 □ M 2X□ F **Director** VIRGINIA APRIL 17 1942 69 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🏋 Yes 2 □ No LANDOVER MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 20785 USA 3305 DODGE PARK ROAD within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ BLACK Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 10TH CHILDCARE PROVIDER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Mental ည PEARL BOWMAN ABRAHAM DUNKLEY permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 DODGE PARK ROAD LANDOVER, MARYLAND 20785 ROSA CURTIS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State ROSE GARDEN CEMETERY 3/3/2012 SOUTH BOSTON, VIRGINIA 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee once 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physici an METASTASIS CANCER disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last the aftending physician the dria Physician/Medical Box 68760 detached for use as f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other fermions IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signe, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 X No 2 🗌 No 1 Tes 25. Was case referred to medical Division of Vital the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 1 XNatural 5 Pendina within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Hospital Medical 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signati 29c. License number FEBRUARY 27, 2012 D31528 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6128 LANDOVER ROAD CHEVERLY, MARYLAND 20785 MARGARET AKPAN MD 31. Date filed (Month, Day, Year) State FEB 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}24, February Physician/ 2012 9:00 a M Sprinkel Ingrid G. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Owings Mills 3005 Walnut Avenue If Under Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 213-32-7115 **Director** 1 M 2 X F 82 April 25, 1929 New York Usual Residence of Decedent Show 10d. Inside City Limits or 28a-f show notified at 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No MD Baltimore Owings Mills 10g. Citizen of What Country? ō 10e. Street and Number ral", or items 23a or Examiner must be Funeral 21117 U.S.A. 3005 Walnut Avenue "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify If Yes, Give White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Bendix -Allied Signal Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked oth any injury or other trainment 17. Father's Name (First, Middle, Last) Carl Laue Anna Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21117 Owings Mills, MD3005 Walnut Avenue Bonnie Heavener Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 2/28/12 Owings Mills, Maryland St Thomas Cemetery 22. Name and Address of Facility Signature of Euneral Service License 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 ken Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Physician 7/12-102-24-11 concer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Exami requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as the l IF FEMALE ise s 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No the Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law read hours after death.
 Funeral Director: After this certificate has be a full or a full prior to completion of cause of death? page 2 : performed? 2 No 1 TYes 2 AN 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Matural 5 Pending 1 Yes 2 No Accident
Suicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registra 's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Day 7 2 Physician/ 4:22 PM Levin Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Maryland Medicul Cit If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Davs Hours Min (Month, Day, Year) **Director** 1 ★M 2 🗆 F 52 219-80-1237 01 26 60 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 7100 Saint Lauren Ct. 21226 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 SpecifyBlack If Yes, Give Year or Dates 1 ☐ Yes 🌂 ☐ No Specify: "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Anne Arundel Co. Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools 12th grade 2yrs Area Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o Joseph Simms Helen Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is 7100 Saint Lauren Ct., Curtis Bay, Md 21226 Dorothera Simms-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2012 Woodlawn, Md King Memorial 21. Signature of neral Service Licensee March Funeral Home (West) 21215 4300 Wabash Ave, Baltimore, 3a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Intracoanial disease or condition resulting in death) ay Medical Due to (or as a consequence of): Examiner is blog to ma year Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lot as a consequence off. Examir The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, thrombosis 2 No 3 ☐ Probably 4 ☐ Unknown Dulmonary Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe#? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 🔲 Yes 1 Xinpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred To the Funeral Director; After 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital 24 hours 29a. Certifier 1 🗡 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22/2012 AU4176435 B100552 MD el 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angela Marie Spurlin chruary 12:521 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season Hospice at Northwest Hospital Randallstown Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 219-82-9085 **Director** 1 □ M **X** X F 51 5/25/1960 NC Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes XX No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 619 Hilltop Road 21228 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc XX Never Married 2 - Married 1 ☐ Yes 2XXNo If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. White 3 Widowed 4 Divorced Completed Year or Dates 2 should be filed within 72 hours and Mental Hygiene.
7 is marked other than "natural traumatic event, the Medical Extraumatic event event. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jake Spurlin Eunice Pearl Vann injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 619 Hilltop Road Catonsville, MD 21228 Mr. John Bibeault / Boyfriend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State 4 Donaffon 5 Other (Specify) Atlantic Crematory 2/28/2012 Glen Burnie, MD 21. Sign Servi Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1 Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Breast cancer ₽nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed 1 Yes 2 No 1 🗌 Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) nospice 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deaun.

To the Funeral Director: After this of a manietely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

1 S Ryapahu M D 29d. Date signed (Month, Day, Year, D0057465 2/24/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 203 Baltimore MD 2,209 N.S. Royaparse, M.D.

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. 2 0 1	2 05920
_			Reg. No	3. Time of Death
	Physicia Medic		F Discours (itaning)	12 0440
	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of I	0
	* *		BATTMERE WITH NOTON PEDENT OR CLENT BURNIE INNO 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9	Birthplace (State or Foreign
	Funeral Director		211 29 6/19 Months Days Hours Min. (Month, Day, Year)	Country) Cennsylvania
	T OM		Usual Residence of Decedent	10d. Inside City Limits
	aryland a-f sh fied a	Director	Maryland Anne Arundel Millersville	1 ☐ Yes 2XXNo
	or 28.	Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of Wha	it Country?
	s 23a	Funeral	344 Regina Court 21108 United	d States
	death r item iner m			American Indian, White, etc.
920	s after ral", o Exam	ed by	1 Never Married 2 X Married 1 X Yes 2 No 1955 - If Yes, Give 1958 1 Yes . 2 No Specify: Specify:	White
2-0	within 72 hours after death with the Maryland gient then "natural", or items 23a or 28a-f sho er than "hatural", or items 25e or 28a-f the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busin (Give kind of work done during most of working	ess/Industry
21215-0036	thin 72 ene. than he Me	Com	Elementary/Secondary (0-12) College (1-4 or 5+) Senior Systems Engineer Compute	ers
d 2	lled wi Hygie other rent, t	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
ylar	d be f Menta arked	၉		
Maryland	should be filed wit h and Mental Hygie 7 is marked other traumatic event, th		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	
	and 2 Healt tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Cit	21108 ty or Town, State
ош Ш			1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	lle, Maryland
Baltimore,	artro	- 53	21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral &	
00	Der Imp		M01121 Services PA; 1 2nd Ave SW; Glen Bur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	
			shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
ر مانگھر	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. (OMPLIATION OF CMPH SEMA) Due to (or as a consequence of):	
	Examiner		1. Convention list conditions	
	p t	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	
	ecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
09	ate be executed ohysician and the burial-transit	dical		
6876	death certificate be executed ne attending physician and ed for use as the burial-transi	Med	¥ IF FEMALE:	
9 X	ith cer ittendii or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	
Box	ss that the death certifics igned by the attending p be detached for use as	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	
P.O.	that the			
ds,	equires en sig ould b	ted	1 Yes 2 No 3	Probably 4 Unknown
Division of Vital Records,	law re has be le 2 sh	Completed by	24a. Was an autopsy pric pric pric pric autopsy performed?	re autopsy findings available or to completion of cause of oth?
Ä	n: The ficate or, pag			Yes 2 No
Vita	ysicia is cert direct	To Be	m examiner?	Specify)
o	ing Ph			
sion	death ctor: A y the f	Certificate:	Accident Investigation	or Rural Route Number,
ΞĔ	al or A s after I Direct			
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check (as stated. the cause(s) and manner stated.
	thin 2.	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man 29b. Signature and title of certifier 29c. License number , 29d. Date signed (A	ner as stated.
	L S H S		D56854 2/23/1	2
	"XIA.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZUNNE KERR - 301 HUSTING DEIVE GLENBURNE MD-	7.01
)		04 Date filed (Manth Day Voor) 00 Decistory Compture	ZICE
	Sta Registr		and the second	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e f perFH, G924, 2/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SERNARD VIAVICZ 07:00P M FEBRUARY 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5833 PARK HEIGHTS AVENUE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthplac Country) MD 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 🛛 M 2 🗆 F Hours 10719/1916 212-09-9433 95 Yrs **Director** Usual Residence of Decedent 3a or 28a-f shov be notified at 10a State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 5833 Park 2803 DAMA 10g. Citizen of What Country? ms 23a must be Funeral Heights Avenue USA iral", or items 2 Examiner mus . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE "natural", 3 🗆 Widowed 4 🗆 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. SUPERVISOR STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of other traumatic even 2 MAX SIAVITZ MINNIE KIRSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE SIAVITZ / WIFE 2434 W. BELVEDERE AVENUE, BALTIMORE, MD 21215 2Cb. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN 02/24/2012 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Interval Between Onset and Death Phusician/ MYDGAMIM IN FARCTION disease or condition MIO Medical resulting in death) Examiner Corrowing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Lirector: After this certificate has completed filled in by the funeral director, page 2 a autopsy performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 2 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 133977 2/43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto Mel 2/209 Golds 2835 JM/A 31. Date filed (Month, Day, Year) State FEB 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Center Wicomico allisb 9. Birthplace (State or Foreign Date of Birth **Funeral** Hours (Month, Day, Year) Country 1 M 2 D F Director 12-24. or 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Yes 2 ☐ No WICOMIC 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 Yes 2 No Completed 3 Widowed 4 Divorced r than "nature the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Important: If item 27 is marked other i any injury or other transman. Be 18. Mother's Name (First, Middle, Maiden EVELYN MATILDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SISTER IN LAW 167 BARRARA RD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗌 Burial 2 🗹 Cremation 3 - Removal from State ARUNDEL CREMATORY 2-25-12 ODENTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 23a. Part 1. Enter the discu Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seque, tially liet conditione, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ig physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes Yes Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 Yes 1 Natient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) work?
1 Yes 2 No iniury 1X Natural 5 Pending M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completely filled in by 1 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

DHMH 17 Rev 06-2011

State Registrar Toch

on who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		State of M	aryland		artment of H <i>tificate of D</i>			giene Reg. No. 2	12	05023
	Dii-i-		1. Decedent's Name (First, N	iddle, Las						2. Date of Dea	th		3. Time of Death
	Physicia Medic		Marion		'I'a 	ylor				Month Feb.	26, 201	ear 2	3Ñ15A ^M
	Examin	er	4a. Facility Name (if not instit	_					Location of Death		4c. County of		
	6		Charlotte 5. Social Security Number	Hall T6.Se				Charlo	tte Hal			ary	
	Funeral Director		421-36-754 Usual Residence of Deceden	3 1	X M 2 □ F 7. Age	e (In yrs. last 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 01-13	7, Year) -25	. Birthpl Counti	lace (State or Foreign ry) M I
	ryland t-f show ied at	Funeral Director	10a. State 10b. Co	unty		10c. City, To						10	0d. Inside City Limits 1 ☐ Yes 2 🕌 No
	or 28a notif	Dire	MD St 10e. Street and Number	. Ma	rys	Cha	arlot	tte Hall			10g. Citizen of Wha	1 C = 1 = 1	
	vith th	ral		10++	e Hall R	550		2062	2		USA	t Count	ryr
(0	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 Never Married 2		12. Was Decedent E Armed Forces? 1 XYes 2	ver in U.S.	13. \	Was Decedent of His f Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race -		ın Indian, tc.African
21215-0036	ural", LExar	ed b	3 ☑ Widowed 4 ☐ Divo		If Yes, Give Year or Dates.	110	1	Yes 2 🕅 No	Specify:		Specify: A	mer	ican
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121	within 7 giene. ser than t, the Ma	Completed	Elementary/Seconday (0-	12)	College (1-4 or 5	+)	life. D	kind of work done do 0 NOT use retired) Laborer			Lumber	Co	mpany
р Б	filed will all Hygid of other svent, t	Be (12th Grade 17. Father's Name (First, Mid	dle, Last)	NA			10	18. Mother's Name	e (First, Middle, I	Maiden Surname)		
lan	should be fill and Mental is marked o	မှ	Marion		Taylo	r			Ettru		Por	ter	
ary	and Market is ma	.,,	19a. Informant's Name/Relat				19b. Mailir	ng Address (Street a	nd Number or Rura	l Route Number,	City or Town, State	, Zip Cı	ode)
Σ	ealth m 27		Adrienne S	tree	ter-Niec	е	P.O.	. Box 72	1092 B	erkley	, Michi	gan	48072
Baltimore, Maryland	t of H If itel		20a. Method of Disposition 1	tion 3 🗆	Removal from State	20b. Plac cem	e of Dispo etery, cren	sition (Name of natory or other place	e) [Date	20c. Location - Cit	y or Tov	vn, State
Ξį	t. Pag tmen rtant:		4 Donation 5 Ott	er (Specif)	Garr		n Forest			Owings I		
Bal	permit. Page 1 and 2 should be fi Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev	1/2	21. Signature of Funeral Serv	ice Licens	tani	ān		Name and Address N. G					P.A. MD 21217
			23a. Part 1. Enter the diseas shock, or heart failure.	e, or comp List only or	lications that saused le cause on each line	the death. D	o not ente	er the mode of dying	, such as cardiac c	r respiratory arre	est,		Approximate Interval Between
	Physician/ Medical	11/4	Immediate Cause (Final disease or condition resulting in death)		a Coro	e57	ve.	Hear	t fai	lure	2		Onset and Death
	Examiner		resulting in death)	ſ	Due to (or a	onsequen	ce of):						
		ner	Sequentially list conditions, if any leading to immediate		b. Due to (or as a	neut/eathup t	Die Liff(c						
	uted d ansit	ami	cause. Enter Underlying Cause (Disease or linjury that initiated events	5									
	icate be executed physician and sthe burial-transit	edical Examiner	resulting in death) Last		Due to (or as a	consequen	ce of):			- -			
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687	ertifica ding p		IF FEMALE:		23c. If yes, outcome	of pregnancy	,						
. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live Birth 4 Pregnant at	2 🗌 Fetal de	eath 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date o Month		y Day Year
P. 0.	requires that the de been signed by the should be detached	y Pł	Part II. Other significant cor	ditions co	ntributing to death be	ut not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribu	e to the	cause of death?
S,	puires en sigr uld be	Completed by	Chronic	_ ()	pztru	CHIV	e 1	ulmon	ary	1 🗆 Y	es 2 No 3 [Proba	ably 4 🗆 Unknown
Records,	as bee 2 sho	plet	Diseas	0;	ESSE	tra	al 1	Hyper	tensio	24a. Was a		autops	sy findings available
Rec	Physician; The law If this certificate has aral director, page 2 s	Som	Huser	10	domic	3.		71		perform	med? deat		
<u>e</u>	cian; ertific ector,	Be (25. Was cas r d to pied examiner?	ical					ce of Death heck				
<u> </u>	Physic this c	10	1 Yes 2 No			ent 2 ER			4 Nursing Ho		ence 6 🗆 Other (S	pecify)	
0 0	ding I h. After funer	Certificate:	1 Natural 5 Pe		28a. Date of injur (Month, Day	; Year)	b. Time of injury	28c. Injury work?	' ' ' '	28d. Describe ho	w injury occurred		
Sio	Atten deat ctor: y the	rtific	3 Suicide 6 C	estigation ould not be	28e. Place of Inju	rv - At home	, farm, stre		(es 2 1 1/6	28f Location (St	reet and Number o	Rural F	Route Number
Division of Vital	al or / s after I Dire d in b		4 Homicide de	termined	building, etc	. (Specify)	,,	, , , , , , , , , , , , , , , , , , , ,	l.	City or Towr		rigi ca r	iouto rumos,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical			ician: To the best of								
	the H thin 24 the F mplet	Me	only one) 3 D Certif	ying Nurs	e Practioner: To the I	pest of my kn	owledge, o	eath occurred at the	time, date and place	e, and due to the	cause(s) and manne	r as stat	1
	다.jk 년 8		29b. Signature and title of cer	7.	1011/	16	1.6	29c. License	number	2	9d. Date signed (M	onth, Da	y, Year)
	'		30. Name and address of per	son who o	ampletêd cause of de	eath (Item 22	a) (Type P	rint)	212	771	010		110
1			Maries	x Y	IN A	294	1491	Charla	HeHall	RdCh	adotte	Lal	IMPROXA
	Stat Registra		31. Date filed (Month, Day, Ye FEB 2		3. Registra	r's Signature	ho.	N.J					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** X6201 William pruar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** John Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M M 2□ F Months 65 216-48-2159 Yrs. Director 10-10-1946 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Baltimore 1KYes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 2826 Mayfild Avenue 21213 USA items 23a Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 ☐ Married Maryland 21215-0036 9 Specify: White 1 ☐ Yes 2 🗷 No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) self employed Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental HIMportant: If item 27 is marked oth any injury or other traumatic eventant in the standard or other traumatic eventants. Be Francis Thawley Mildred Jockish 19a. Informant's Name/Relationship (Type. Print) friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelo Luedtke 847 S. Kenwood Ave., Baltimore, MD 21224 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/29/2012 Baltimore, MD Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. 21. Signature uneral Service Licensee Zannino Jr. 263 S. Conkling St. Baltimore, MD 21224 disear, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart land Immediate Caus (Final disease or condition **Physician** Sep S15

Due to (o as a consequence of): resulting in deata) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined

Division of Vital Records, filled in by

DHMH 17 Rev 1/2001

State

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

Registrar

huenemen 49
32. Registrar's Signature 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

For State

			StateRegistrar				Cer	tificate of	Death			Reg. N	.21	12	05925
		٦,	1. Decedent's Name	e (First, Middle, L	_ast)						2. Date of De		014	Vace	3. Time of Death
	Physicia Medic		Chai Sur	n Tong							Feb.	23,	^{ay} 201	2	6:15 P M
411.	Examin	_	4a. Facility Name (if	not institution, g	ive street and num	ber)		4b. City, Town,	or Location	of Death			c. County o		
-	Á		Casey H	ouse				Rockv				M	ontgo	mery	
	Funeral		5. Social Security N		. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi			9. Birthp	lace (State or Foreign
ì	Director		369-58-2		1 X M 2 □ F	76	Yrs.				Oct. 2		935	Chir	na
	nd now at	_	Usual Residence of 10a, State	10b. County		10c. City	, Town or Lo	cation						11	0d. Inside City Limits
	arylar a-f sk fied a	50	MD	Montgom	erv		Boyds								1 🗆 Yes 2X No
	or 28	ă	10e. Street and Nun					10f. Zip Code				10a C	itizen of W	hat Coun	tn/?
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	21712 Se	eneca Ay	r Drive			20841				-	JSA	inat oouri	y.
	ems r mu	Ĕ.	11. Marital Status		12. Was Dece	dent Ever in U.S	3. 13. \	Was Decedent of	Hispanic O	rigin? (Spe	cify Yes or No	-	14. Race	- America	an Indian.
(0	er de or it	by F	1 Never Marr	ied 2 🔀 Marrie	Armed Ford	rces? 2 No	- 1	Was Decedent of f Yes, specify Cul			Rican, etc.)			, White, e	
03	rsaft Iral", Exal	ed	3 Widowed	4 Divorced	If Yes, Giv Year or Da	e		1 ☐ Yes 2 🔼 N	o Specify	/:			Specify: P	sian	1
21215-0036	hou fratu dical	Completed	(Sne	15. Decedent's	s Education grade completed)			dent's Usual Occu kind of work done		st of worki	na	16b. i	Kind of Bus	iness/Inc	lustry
21	nin 72 ne. han '	E	Elementary/Seco		College (1-	-4 or 5+)	life. D	O NOT use retired	d)	or or worth	''g	Dog	taura	·n+	
21	ygier ygier her t	Be C			4		Co	OK.	1					uic .	
pu	e filed tal H	10 B	17. Father's Name (it)				1		e (First, Middle g Chan	, Maiden	Surname)		
Maryland	should be filed within 72 n and Mental Hygiene. r is marked other than "r raumatic event, the Med	-	Pork Wa			-	1								
Jai	shot and 7 is n		19a. Informant's Na					ng Address (Stree Seneca							iode)
0	and 2 s Health tem 27		Kam Siu		MITE	I			Ayı			_			
Ore	ge 1 and it of Heal if item or other		20a. Method of Disp 1 Durial 2		Removal from	State	emetery, crer	sition (Name of natory or other pl			Date	20c. l	_ocation + (City or To	wn, State
ţi	t. Pag tmen tant: jury		4 Donation	5 Other (Spe	ecify)	Fin		rney Cre					odbin		
Baltimore,	permit. Page Department or Important: If any injury or once.		21. Signature of Fur	neral Service Lic	ensee	1404	2	Name and Addr	ess of Facil	matic	on Sery	rice.	P.O.	Вох	784 e, MD 2102
	TD2 10 0	-	1/10	and a		M01							Larks	<u> </u>	
				rt failure. List onl	y one cause on ea		1. До пот епт	er the mode of dy	ing, such as	s cardiac c	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (disease or condition resulting in death)		_ a	mentia									Onset and Death
740	Examiner		resulting in death)	1	Due to (or as a consequ	s a consequence of):								
%		r.	Sequentially list co		b. —————									_	<u>.</u>
	ed sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	rlying	Due to (or as a consequence of):										
	and I-tran	xal	that initiated events resulting in death) I	S	C. Due to (or as a consequence of):									+	
_	oe ex ician buria		Todaking in dealing			,	,								
260	cate be executed physician and s the burial-transit	/Medical			d										
68760	hat the death certific ed by the attending p detached for use as		IF FEMALE:	prognant	23c. If yes, out	come of pregna	ncy						23d. Date	of dolive	in.
Вох	ath c atten for u	ciar	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐	months?		Birth 2 🗀 Feta nant at time of d		Ectopic pregnal Other (specify)	ncy				Moni		Day Year
Ω.	the ched	Physiciar	9 Unknown	□ NO	g 🗌 Unkr										
P.O.	hat the ed by deta		Part II. Other signif	icant condition	s contributing to d	eath but not res	ulting in the u	inderlying cause g	given in Par	t I.	23e. Did	tobacco	use contrib	oute to th	e cause of death?
	signe signe ld be	d by	CVA								1 🗆	Yes 2	No 3	B Prob	ably 4X Unknown
ord	require been si should	lete	Chro	onic Kid	lney Dise	ase					24a. Was	an	24b. W	ere autop	sy findings available
ecc		Completed				_					auto perf	opsy ormed?	pr de	or to coreath?	npletion of cause of
- H	sician: The lav certificate has irector, page 2		25. Was case referre		iver Dis	ease		26	Place of De	ath (Chaol		2 X N	lo 1	Yes	2 🗌 No
/ita	sicia certi lirect	o Be	examiner?		Hospital:	In-ations OF	ED/Out= -ti	- 0					o IV I out	(0 :5)	hospice
7	Phys r this eral di	e: To	27. Manner of Death		28a. Date		28b. Time of	28c. Inju	iry at		me 5 L Hes 28d. Describe				повртее
Ē	Attending Pr r death. ector; After th by the funeral	Certificate:	1 X Natural 2 ☐ Accident	5 Pending Investiga	1 1	th, Day, Year)	injury		rk? ∐Yes 2.[,			
Sic	Atter er dea ector by th	1	3 Suicide 4 Homicide	6 Could no	t be 28e. Place	of Injury - At ho	me, faım, str	eet, factory, office			28f. Location	Street ar	nd Number	or Rural	Route Number,
Division of Vital Records,	al or s afte		Troillicide	Gereinilli	buildir	ng, etc. (Specify,)				City or To				
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific etely filled in by the funeral director,	Medical	29a. Certifier 1	Certifying P	hysician: To the b	est of my knowl	edge, death	occurred at the tir	ne, date an	d place, ar	nd due to the o	cause(s)	and manne	r as state	ed.
	n 24 ne Fu ne Fu	Med		☐ Medical Exa ☑ Certifying N	iminer: On the bas urse Practitioner	is of examination To the best of m	and/or inves ny knowledge	tigation, in my opir , death occurred a	nion, death o	occurred at ate and pla	the time, date ice, and due to	and place the caus	e, and due te e(s) and ma	to the cau inner as s	se(s) and manner state tated.
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29b. Signature and	-	n.	0-		29c. Licen					ate signed		
_			11/10/1	16	V 1. 1 0	V-20		A				- /	_ /	. —	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

immediate lerlying or injury	Due to (or as a consec	quence of):		
nts) Last	Due to (or as a consec	quence of):		
8	· ·			
nt pregnant 2 months? No	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ificant conditions of	contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
4			1 🗆 Yes	2 No 3 Probably 4X Unknown
onic Kidn	ney Disease		24a. Was an	24b. Were autopsy findings available
l Stage Li	ver Disease		autopsy performed 1 \(\sum \) Yes 2 \(\foxX\)	
rred to medical		26. Place of Death (Che	eck only one)	
⊠ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 Residence	6 🛭 Other (Specify) hospice
ath 5 ☐ Pending Investigatio		28b. Time of injury 28c. Injury at work? M 1 \(\text{Yes} \ 2 \subseteq \text{No} \)	28d. Describe how in	
6 ☐ Could not be determined		ome, farm, street, factory, office fy)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
2 Medical Exam	iner: On the basis of examination	wledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurred my knowledge, death occurred at the time, date and	at the time, date and pl	ace, and due to the cause(s) and manner stated.
d file of certifier -	71	29c. License number	29d.	Date signed (Month, Day, Year)
brah	Muter	CRNP R143201	2	23/12
	completed cause of death (Ite		ι	,
Miller,	CRNP 6001 Munc	aster Mill Rd Rockville	, MD 20855	
FEB 2 8	2012 32. Registrar's Sign	B. parks		
39 1 00				

Registrar

31. Date filed (Monti 2 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP 6001 Muncaster Mill Rd Rockville,

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 2012 AM 7:07 TACKIE D'JOMOAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ JAN 169, 19943 TEXAS Director 69 298-38-2658 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must ha matter and 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S LANHAM Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 91st PLACE 20706 USA 9106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 ₹ Yes 2 □ No ARMY If Yes, Give Year or Dates. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 √ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT SOCIAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHNNIE NOVELLA GARRY WARMACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 91st PLACE LANHAM, MARYLAND 20706 BETTY REDMOND NORRIS/FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY : 2/28/2012 RIVERDALE CREMATORY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Se 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Refrection Ph_sician/ Change disease or condition Medical resulting in death) Due to (or as a conse nce of) Examiner Ceselio VAICO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit DETCHIVE (ard that initiated events resulting in death) Last and Due to ar as a consequence of) the a ending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 🗌 No 2 1 Yes completed filled in by the funeral director, 25. Was case referred to æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident atural 1 Tes 2 No M Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: After this certificate

within 2.

Medical

29a. Certifier

(Check

only one)

me and

31. Date filed (Month, Day, State FEB 2 8 Registrar

3 🗍

d title of certifier

Cimul 600 32. Registrar's

of person who completed cause of death (Item 23a) (Type, Print)

🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TAKEMA

29d, Date signed (Month, Day, Year)

02-17-2012

29c. License number

Me

55

Baltimore, Maryland 21215-0036 that the death certificate be executed Box 68760 P.O. Records, Division of Vital Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 0502 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 2012 May Lovenstein Taylor 12:45pm^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 8. Date of Birth **Funeral** Hours May 7, 1 🗆 M 2 💢 F 86 T925 Yrs Director 219-18-0002 Usual Residence of Decedent show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 V No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6027 Emerald Lane 21784 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other th Administrative Assistant Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald Isodor Lovenstein Edna Mae Kuhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a.
Important: If them 27 is v. any injury or other Donald A. Taylor (Son) 6027 Emerald Lane Sykesvile, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Crestlawn Mem. Garden's 3/2/2012 4 Donation 5 Other (Specify) Marriottsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the telath. Do not enter the mode of dying, such as cardiac or lesoiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 4 Pregnant signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 PNo 2 🗖 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) Westminst

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, g924,02/27/2012dhb

Certificate of Death

Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carey Howell Taylor 27 07:24 M 2012 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE, MD SAMARITAN HOSPITAL Baltimore City If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 06/24/1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours Min. Balt. 218-28-6156 84 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Perry Hall Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 USA 28 Bangert Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important If item 27 is marked other any injury or other trainment. 14. Race - American Indian. "natural", or iter Black, White, etc. 1 Never Married 2 🙀 Married Completed by 2 No 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bethlehem Steel Superintendant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anne Howell John Carey Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Bangert Ave., Perry Hall, MD 21128 Mary Ann Taylor - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛚 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2012 Glen Burnie, MD Atlantic Crematory 21. Signat e of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARDIO RELPIRATORY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PULMONARY EDEMA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) CONGESTIVE HEART FAILURE CERTIFICATION APPROVED BY MEDICAL EXA attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical RENAL FAILURE IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Day 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASPIRATION PNEMONIA, SUBDURAL HEMATOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Af er this certificate has perform 1 ☐ Yes 2 ☐ No Hospital or Attendir g Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 100 Hospital Other: မ 1 X Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 X No Subject fell down stairs. 12/24/2011 2 X Accident Investigation **Unknown**^M the Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28 Bangert Avenue Perry Hall, MD 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number Dr. Nutan) RES 000 MD an.

Registrar DHMH 17 Rev 7/2009

State

ray Lois

Barke

NEWEON, GOOD SAMARITAN HOSPITAL, LOCH RAVEN BOULEVARD, BALTIMORE | MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 7 2012

32. Registrar's Signature

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10.00 AM Evelyn Beckett Taylor 2012 tebrigary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Co. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 220-20-7156 1 🗆 M 2 🗓 F 84 06/03/1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Co. Glen Burnie 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7790 Hancock Lane Apt G 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 √ No Specify: Specify: White 3XX Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Beckett Anna Ruth Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cheryl A. Linzey /Daughter Baltimore, Maryland 3611 Kenmar Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2012 Atlantic Crematory Glen Burnie, Maryland Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Hemorrhag disease or condition resulting in death) ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events De o (or as a consequence of) Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a, Was an

Ph_sician/ Medical Examiner attending physician a for use as the burialthat the death certificate be Box 68760 P.O. n signed by t uld be detach

or Attending Physician: The law requires Division of Vital Records,

s certificate has b director, page 2 s

hours after death.

Ineral Director: After this is filled in by the funeral di

24 hours

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

28a-f show

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Department of Health ar Important: If item 27 is any injury or other trau

other traumatic

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Exami Physician/Medical Completed by Be ြို

IF FEMALE

Certificate: Medical

within 2 **To the** I

State Registrar

25. Was case referred to medical 2 No 1 Yes 27. Manner of Death 1 🔀 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined

> 29a. Certifier (Check

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier

1 🔀 Inpatient 2 🗆

28a. Date of injury (Month, Day, Year)

1)066823

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other:

28c. Injury at work? 1 ☐ Yes

26. Place of Death (Check only one)

2 🗌 No

29d. Date signed (Month. Dav. Year) 24,2012

28f. Location (Street and Number or Rural Route Number,

1 Yes 2 No

autopsy 1 ☐ Yes 2 No

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 06-2011

ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 Cell

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	_	For State Registrar		State o	of Mary			tment of l ificate of	Health and Death	Mental Hy	/gien Reg. N	0011	2 0	5931	
Physiciar	1/	1. Decedent's Nam		Last)					-	2. Date of D Month FEBRUA		Day Year		ne of Death	
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permi Depar Impo any ir once.		21. Signatura a	Service Lic	96				Name and Addre	TERSTOWN			N & BROS SVILLE.		C. 1208	
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Physician/ Medical Examiner		disease or condition resulting in death)		a. Due to	(or as a con	neequence o	1):							m?	
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physic	edic			d											
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buriar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Yeart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part											23d. Date of d Month	elivery Day	Year	
es that th signed by be detac	l by Ph	Part II. Other signin	ficant condition	s contributing to c	leath but no	ot resulting in	n the und	derlying cause g	iven in Part I.	1		o use contribute			
requir been s	letec			 -						24a. Wa				ngs available	
The law ate has page 2 s	Completed									aut	opsy formed?	prior to death?	completion	of cause of	
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Phys r this eral dir	1 Inpatient 2 ER/Outpati							3 DOA 28c. Inju	4 ☐ Nursing F	28d. Describe		6 Other (Spe	ecify)		
nding ath. r: Afte	icat	1 Natural 2 Accident 3 Suicide	5 Pending Investiga		th, Day, Yea	a <i>r)</i> ir	njury	WON	k? Yes 2□No			,			
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e Hospit 24 hour e Funera	29a. Certifier 1. Certifying Physician: To the best of my knowledge, dear (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge							r investigation, in my opinion, death occurred at the time, o				ne, date and place, and due to the cause(s) and manner state			
To th within To th comp	<	29b. Signature and			_ 3550	,	J-, 20	29c. Licens		P	29d. Date signed (Month,)	
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State Registrar R. Vill

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gary B. Vincent 02 5 2012 Medical 10:07a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year)
06 17 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. g. Birthplace (State or Foreign **Funeral** Country) Director 220-64-8178 56 1 XM 2 □ F 55 DC Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1X Yes 2 No MD NA Baltimore ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a 5745 Green Rose Lane 21215 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. or ρ 1 Never Married 2 Married 1 Yes 2 No within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 - Widowed 4 X Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Disabled Disabled Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe Richard Powell Lorraine E. Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Ted L. Cobb-Brother .5**5**54 Canbridge Drive, Lathrum, CA 95330 other 1 Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Woodlawn 2/25/2012 Woodlawn, Md 21. Signatur of Funeral Service Licen March F/H West 4300 Wabash Ave, Baltimore, Md 21215 1. Enter the disease, or complications that k, or hear failure. List only one cause on e the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Par caused Approximate shock, or hear Interval Between Immediate Cause (Fin Onset and Death Physician/ disease or condition DIDNAM month Medical resulting in death) **Examiner** 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s consequence of iabeles Due to (or as a consequence of): ŵ resulting in death) Last Physician/Medical that the death certificate be Box 68760 the as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 X No 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 KER/Outpatient 3 DOA this eral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after hours a Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To/the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

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Ste. 136

20, 2012

Baltimore, mo 21218

February

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Watkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Maryla		artment of F <i>tificate of L</i>		Mental Hy	rgiene Reg. No.20	12	05933
F	Physicia	nn/	Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death
Carlos	Medi	cal	SARAH E 4a. Facility Name (if not institution, give str		VOGELHU			Febru	1 /	, 2012	2020 M
	Examir	er	UNION MEMORIAL 1	,		· · · · ·	Location of Deat	h	4c. County	of Death	
	Funeral	г	5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth		e (State or Foreign
	Director		215-24-1196 1 □ Usual Residence of Decedent	M 2 X) F	Yrs.	World S Says	, riodio , wiini.	07/29		Country)	MD
	show dat	ţo	10a. State 10b. County	10c.	City, Town or Loc	ation				10d.	Inside City Limits
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	ith the	ral	10e. Street and Number	30AD #100		10f. Zip Code	1.0		10g. Citizen of		
	tems er mu	Funeral	3801 CANTERBURY I	2. Was Decedent Ever in		Vas Decedent of H	ispanic Origin? (S	pecify Yes or No	US.	:e - American I	ndian,
36	within 72 hours after death with the Maryland glehe. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	þ	1 Never Married 2 XMarried	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Yes, specify Cuba		o Rican, etc.)	Blac Specify	ck, White, etc.	
0	atura ical Ex	Completed	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates.		ent's Usual Occup		<u>.</u>	16b. Kind of B	WILL	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	10 E	HARRY	т.т	NDEN		18. Mother's Nai	me <i>(First, Middl</i> e	, Maiden Surname	e) LYON	NS.
lary	should and M is man		19a. Informant's Name/Relationship (Type			g Address (Street a	-	ral Route Numb	er, City or Town, S		
ა დ	and 2 s Health tem 27		MARTIN Z. VOGELHU			1 CANTER	BURY ROA	D , #409			
nore	Page 1 anneut of Hant: If ite		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re	emoval from State		atory or other plac		Date	20c. Location -		
altin	permit. P? Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	ÇAF		EMATION, Name and Addres				PSTEAD,	
<u>~</u>	permi Depar Impo any ir		19-6	_		900 REIS					21208
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) 09	cate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse	equence of):						
). Box 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Tune Hours after death. The Funer Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Da Mo	te of delivery nth Day	/ Year
ds, P.O.	quires that en signed ould be dei	by	Part II. Other significant conditions control	ibuting to death but not r	esulting in the ur	derlying cause giv	en in Part I.		obacco use contr		ause of death? y 4 🗆 Unknown
Division of Vital Records,	: The law recate has be ; page 2 shd	Completed							ormed?	Were autopsy forior to comple death? 1 Yes 2	findings available etion of cause of
Ta	ding Physician: The h. After this certificate funeral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	spital:	7	100	ace of Death (Chec				
<u>,</u>	g Physer this neral d	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury	4 <u> </u>		dence 6 Othe		
0	ending eath. or: Aftu	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 🗆 No				
DIVIS	ntal or Attending P urs after death. ral Director; After t illed in by the funera	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Tov	Street and Numbe vn, State)	er or Rural Rou	ite Number,
:	Host 24 ho Fune letely f	Medical	(Check 2 Medical Examiner	an: To the best of my kno : On the basis of examinat	ion and/or investig	gation, in my opinio	n, death occurred	at the time, date a	and place, and due	to the cause(s	and manner stated.
7	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Σ	only one) 3 L Certifying Nurse F 29b. Signature and title of certifier	Practitioner: To the best o	i my kilowieage, (29c. License		lace, and due to	the cause(s) and m 29d. Date signed		
			Calcult			ATO	24389	46	Februar	V 22	2012
	6		30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type, Pr	int)	Lu Cont	4.00	Satione	p Man	2012 yland 21218
	Stat	e	31. Date filed Worth, Day, Year, 12 FEB 2 8 2012	32. Registrar's Sign	natura de Mar	VIII VICES	7 14 1611	HERRY , L	-umillion	1-104	WILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 28 28 Stanley Wernsing 2012 A^{M} 2:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Garden Way Calvert Lusby Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Months Days Hours Min. | Nov. 19, 1945 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Maryland 1 ★M 2 □ F Director 66 Nov. 218-42-4669 Usual Residence of Decedent "natural", or items 23a or 28a-f show odical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Anne Arundel Lothian 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 814 Rustic Lane 20711 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. à 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Warehouse Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Chester Sieracki Michaelina Ustach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexa Burley / Daughter 95 Garden Way, Lusby, Maryland 20657 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory Inc | 02/28/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

58m

State

29b. Signature and title of ce

30. Name and address

Registrar DHMH 17 Rev 7/2009 person who completed cause of death (Item 23a) (Type, Print)

oble WI

29c. License number

238 Merrimac

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Physician/ Month Year George Edwin Walton 0721 im Fabruary 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, 9r Location of Death Examiner 4c. County of Death Agnes Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Jahn 10, Year 929 Hours 220-24-6109 83 Yrs. MaryTand Director Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland | Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5011 Wilkens Ave. 21228 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Department Of Defense Inspector - Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charlotte A. Day Charles R. Walton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen M. Walton /Wife 5011 Wilkens Ave., Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State Lakeview Memorial ParkFeb. 28, 2012 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facking BROSE FUNERAL HOME, INC. 21. Signatur of Funeral Service Lifensee Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between et and Death Immediate Cause (Final disease or condition Physician Attensilante avdio vascular - Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive heart tailure 24a. Was an autopsy performed Yes 2 this certificate completed filled in by the funeral director, 25. Was case referred to medical examine?

1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068107 February 22, 2012

State Registrar Mier

MA

900 South Caton

Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

P.O.

Division of Vital

egistrar's Signature

8 2012

			For State Registrar		State of Ma	aryland /	•	tificate of	heaith and M Death	ental Hy	giene Reg. No	2010	05937
	Physicia	an	1. Decedent's Name (First,		esa Wil:	con				2. Date of De Month	Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not ins			5011		4b. City, Town, o	r Location of Death	2	24	2012 County of Death	
	Examin	ei	FRANKLIN :	-		pital			sedale			Balli	
	Funeral Director		5. Social Security Number 214–16–556		7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	ay, Year)	Cot	place (State or Foreign intry) MD
	land ow		Usual Residence of Deceded 10a. State 10b. C	County		10c. City, To	own or Loc	eation					10d. Inside City Limits
	a-fsh	ctor	MD Ba	ltimo	re	No	otti	ngham					1 □ Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 4719 Bal	lygar	Road			10f. Zip Code 21	236		10g. Ci	itizen of What Cou	ntry?
T. 5-0036	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, I'm Modical Evanitation or items to redified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☒ Widowed 4 □ Di	Married vorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔏 I If Yes, Give Year or Dates:	No	1	□Yes 2. TANO		cify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: Wh	etc. ite
215-	in 72 h	plete	(Specify only	cedent's Edu highest grad	e completed)	- 0	6a. Deced (Give life. L	ent's Usual Occup kind of work done OO NOT use retired	pation during most of workin d)	ng	16b. K	(ind of Business/li	ndustry
رِّحِ 212	e filed within al Hygiene. f other than ' went, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		memaker			10	wn home	
ma Vland	eve be	Be	17. Father's Name (First, M						18. Mother's Name				
>	s 1 and 2 should be of Health and Mental item 27 is marked cother traumatic even	မ	Michael 19a. Informant's Name/Re				IQh Mailin	a Address (Street	Kathe: and Number or Rura			y Long	in Code)
Mar	27 = 27 i		Katherine										
s o	es 1 a of Hea		20a. Method of Disposition 1 ☐ Burial _2 🛣 Crem			200. Place	e ot Dispos eterv. cren	sition (ivame of natory or other plac	ce) Di	ate	20c. L	ocation - City or T	own, State
wils o altimore,	permit. Pages Department of Important: If its any injury or o		4 □ Donation 5 □ Ot	her (Specify)	_	Bayv	7iew	Cremat	ory 2/25	/12	Ba	altimor	e MD
Bal	permit. Departn Importa any inju		21. Signature of tuneral S	er/ice/Licens	BO	10	22	Name and Addre	30			ve. Bal	
	Physician		23a. Part - Enter the diseashock, or heart failure Immediate Cause (Final disease or condition	ase, or comple. List only or	cations that caused ne cause on each lin	the death. Ene.	Do not ente	er the mode of dyin	lly Fune: ng, such as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequence	ce of):	A-c 0	Pair		· 1		
		e.	Sequentially list conditions if any, leading to immediate	l l	Dur to (or as	a consequence	ce of):	ASSOCIA	TEXS YOUR	mon	14-	_	
ď	tificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to (or as	a consequen	-	Mon	FAiry	ne			
68760,	ate be hysicia he bur	edical		L.	ı. <u>-</u>								
			IF FEMALE:		3c. If yes, outcome	of pregnancy	,				T	1	
P.O. Box	Physiclan: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use	Physician/N	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown	ını	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3 □	Ectopic pregnand Other (specify)	y 		ĺ	23d. Date of deli Month	very Day Year
	ss that gned b	y P	Part II. Other significant co		ntributing to death b	ut not resultin	g in the un	derlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ord	require een si nould b	ted	DEMEMON	+			-			1 🗆	Yes 2	No 3 Pro	bably 4 Schnknown
Division of Vital Records,	: The law cate has b page 2 st	Completed by								24a. Was auto perfo 1 □Yes	psy ormed?	death?	opsy findings available ompletion of cause of 2 ∰No
VIII:	siclan certifi rector	Be	25. Was case referred to mexaminer?	-	lospital:			Oth	26. Place of Death				
of	g Physer this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date of Inju	ent 2 ER/	b. Time of	28c. Injur	vat 2	ne 5 ☐ Resi 8d. Describe		6 ☐Other (Spec	ify)
ion	Attending r death. sctor: After by the funer	atio	2 Accident	Pending nvestigation	(Month, Da	y, Year)	Injury	M 1 □	k? Yes 2 □ No				
Divis	tal or Atters of all Directors of in by the	Certification: To		Could not be determined	28e. Place of Injubulding, etc.	ury - At home, c. (Specify)	, farm, stre	et, factory, office	2	8f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	al Route Number,
		Medical	(Check only 2 Me	edical Exami		f examination		restigation, in my o	me, date and place, a opinion, death occurre		date an	d place, and due	to the cause(s)
	vith vith con	2	29b. Signature and title of c	certifier	PH	199Ar	J	29c. Licens	064555		29d. Da	ate signed (Month	
2			30. Name and address of p	1	4	eath (Item 23	a) (Type, F	Print)	6.74 3	20/ 12	2/	traded	2012 = WD 212
	Stat	e	31. Date filed (Month, Day,	Year)	87 82 Registra	ar's Signature	7	W BL	5W (7 3	N 8 0	w (U	inval	, , , , , , , , , ,
./	Registra	ar	FEB 2	8 2012	Denter	B.	gar		·				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:27 PM Wittia 02 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kernan Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth Jarrica Lay, Year) 1936 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**%** M 2□ F 215-30-7462 Director Balt., Maryland Usual Residence of Decedent 10a State Show 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-f shov other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Director Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 200 Kali Court 21120 of America Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 3 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Car dealer management Automobile Sales 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karl R. Wittig Antoinette DeCerbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Wittig/ wife 200 Kali Ct. Parkton, Maryland 21120 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)

Evans Funeral

Chapel Bel Air 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 26, 2012 Forest Hill, Maryland 21. Signature of Funeral Service & cense 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Ctr. PDCe MU 2325 York Road Timonium, Maryland 21093 2325 York Road Timonium,
234. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ischemic cardiac arrhythmia Minutes /Medical Due to (or as a consequence of): **Examiner** Atheroselectic coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Years Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE use (23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy į in the past 12 months? Day Year 5 Other (specify) P.O. the a 1 Yes 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed: page certificate 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a To the Funerel D the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Themas J. Merkle February 24, 2012 D0070452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Merkle, M.D. 2200 Kernen Drive, Baltimore parks 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 8 2012 10 min Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death ELRAB ETH Physician/ Mont Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview at Mays Chapel Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Day, Ye. 1 03, 82 Director 029-20-8663 1 🗆 M 2 🗸 F Jul 1929 Massachusetts Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director NA 1 X Yes 2 🗆 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 821 Park Ave. 21201 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ⚠ Widowed 4 ☐ Divorced "natural" Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Mongomery County Elementary/Secondary (0-12) College (1-4 or 5+) the Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George R. Tanch Anna Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other to once Brett Walton /Son 821 Park Ave. Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 25 Beltsville, Maryland Chesapeake Crematory 2012 Signature of Funeral Service Licensee 22. Narcand Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Demention disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) Natural Accident 5 Pendina injury work?
1 Yes 2 No filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title ed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore,

Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day WHITTINGTON AMELA 02-2 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE GRILCHRIST BAUTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 212-58-3142 1 □ M 2 🎾 F Director 06-12-1953 MO 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified MD BAUTIMORE 1X Yes 2 No 10e. Street and Number ō 10g. Citizen of What Country? ms 23a or must be r Funeral USA DARTMOUTH 21234 items? permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natu
any injury or other traumatic event, the Medical
once. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) VER1201 ELEPHONE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ ESTHER WHITTINGTON JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. WHITTINGTON (Brother) KOAO. MD. 21229 100 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 13/2012 4 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERAL SUS . Signature of Funeral Ser 23a. Part 1. Enter/he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician disease or condition Cauc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ģ in the past 12 months?
1 ☐ Yes 2 M No Month Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown detached 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Hother (Specify) HOS After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and little of dertifier 29c. License number 29d. Date signed (Month. Day, Year

State

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FEB 2 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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P		u	Registrar 1. Decedent's Name (First, Middle, Last)	-42.3		uncate of L	- Calli	2. Date of D		2012	3. Fime of Beath
	Physicia Medio		James	Williams	3			Month Februa	my ZS	ZolZ	9:404 M
	Examin	er	4a. Facility Name (if not institution, give street	•		4b. City, Town, or			4c.	County of Deatl	
Special Services	Funeral		Season's Hospice 5. Social Security Number 6. Sex		s. last birthday)	Randa If Under 1 Year	allsto		irth	Baltin 9 Birt	nore hplace (State or Foreign
	Director		227-84-0786	12□F 58	Yrs.	Months Days	Hours N	Min. (Month, D	lay, Year)		intry) NC
	nd Jow Jat	_	Usual Residence of Decedent 10a, State 10b, County		City, Town or Loc	eation					10d. Inside City Limits
	larylar 3a-f sl iffied	Director	MD NA		Balti						1X Yes 2 □ No
	the N or 28		10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
	n with	Funeral	2501 Violet Ave A	pt 601N		212	215			U.S.A	١.
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		11. Marital Status 12. 1 □ Never Married 2 🗶 Married	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 █️XNo		Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.))- 1	4. Race - Amer Black, White	
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12	thin 73	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	O NOT use retired)	J	, , , , , , , , , , , , , , , , , , ,			
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Maryland 21215-0036	d be filed Mental Hy arked oth atic event	မ	Carmon Williams	Sr.			Iris	Spruill		,	
lan,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, I					Rural Route Numb			
	e 1 and 2 g t of Health If item 27 or other tr		Darlene Williams 20a. Method of Disposition				: Ave	Apt 601			
Baltimore,			1 ☐ Burial 2 【XCremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)		o. Place of Dispos cemetery, crem On-Si	atory or other place		Date 75/2012	İ	cation - City or	
altir	permit. Page Department Important: I any injury or once.		ature Funeral Service Licensee	4/	_	Name and Addres			Dal	timore	, MO
m	m De de de de de de de de de de de de de de	1	I simula l'	Moint	M 5	rch F/H 300 Waba	l West sh Av	e, Balt	imor	e, Md	21215
		'	23a. Part 1. Enter the disease, or complicat stock, or heart failure. List only one ca	ions that caused the deause on each line.	eath. Do not ente	r the mode of dying	, such as card	diac or respiratory a	irrest,		Approximate Interval Between
-12	Ph_ici_// Medical		Intrinediate Cause (Final disease or condition resulting in death)	Prostate		•					Onset and Death
ممسيده	Examiner			Due to (or as a conse	equence of):						
		iner	Sequentially list conditions, b if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						
	cuted	Examiner	Cause (Disease or injury that initiated events c	5						- 1	
	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence oi).						
2.09	ficate g phys	l edical	d								
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transis.	Physician/M	200. Was decedent pregnant	If yes, outcome of preg	nancy etal death 3	Ectopic pregnancy	,		2	3d. Date of deli	very
Bo	e death	ysici	1 Yes 2 No	4 ☐ Pregnant at time og ☐ Unknown		Other (specify)				Month	Day Year
ö	hat the ed by detac		Part II. Other significant conditions contrib	outing to death but not r	resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ŝ	uires t n signi uld be	ed by						_ 1 🗆	Yes 2	No 3□Pr	obably 4 🗆 Unknown
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ĕ	sician: The law significate has the sirector, page 2 s	Completed						— auto perf 1 ☐ Yes	ormed? 2 No	death?	2 No
ā	ician: certific rector,	Be	25. Was case referred to medical examiner?	ital:		26. Pla		Check only one)			to at lausais a
Division of Vital Records,	Phys r this eral di	e: To	TLI fes Z Z No	1 ☐ Inpatient 2 2 28a. Date of injury	ER/Outpatien 28b. Time of	3 DOA 28c. Injury	4 □ Nursin	g Home 5 Res 28d. Describe			tient hospice
ono	anding ath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆 Y	yes 2□No	- 1	,		
NISI	or Atter fter de lirecto in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e, Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (City or To		Number or Rura	al Route Number,
5	pital ours a eral D filled		29a. Certifier 1 Certifying Physician	a. To the heet of my kno	wledge death e	coursed at the time	data and place	and due to the	auga(a) and	d mannor on etc	tod
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pra	On the basis of examinat	tion and/or investi	gation, in my opinior	n, death occurr	red at the time, date	and place, a	and due to the c	ause(s) and manner stated.
_	To the Com		29b. Signature and title of certifier NS Ry walm	0 M+1) .		29c. License			29d. Date	signed (Month,	Day, Year)
D	W					1 80	0571	+65	2	120/1	۷
~			30. Name and address of person who compl W - S RWWWYSEMD	leted cause of death (Ite 2835 J.m.,	em 23a) (Type, Pr	int)	3u linn	465 MD	21	209	
	Stat		W · S RajapakseMD 31. Date filed (Month PEB 2 8 201	32. Registrar's Sign	nature	arkel					
	Registra	r	1 20 0 0 20:	- American	2. C.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Deceden t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ONSON Physician/ PM PEB Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ERU LUSPITAL 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 05 07 Months Days Hours Min. 1 🗆 M 2 💢 F 220-80-7891 **Director** 49 62 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director NA Baltimore MD Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 21216 2805 Elgin Ave hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force ō 1 X Never Married 2 Married þ 2X No Maryland 21215-0036 Yes Black If Yes, Give Year or Dates 1 ☐ Yes X☐ No Specify: "natural", 3 Divorced 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Solo Cup Company Line Packer 12th grade na Be 17. Father's Name (First, Middle, Last) 18, Mother's Name *(First, Middle, Maid*en S*urname)* Doris Wonson Leroy Griffin permit. Page 1 and 2 should be Department of Health and Men Important, If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21220 2213 Vaithorn Road, Middle River, Md Renee Durant-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Woodlawn, Md re of Funeral Service Licensee Signal 22. Name and Address of Facility
March F/H West Ave, Baltimore, Md 21215 4300 Wabash . Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. O et no eath Immediate Cause (Final JON Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical s, P.O. Box 68760 the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv certificate 1 Yes 2 No Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident 1 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) PAUL 05 TY 21201 345 31. Date filed (// ic 8 2012 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ware Judith Physician/ Month Year 3:30 A M FERMANS 17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death North West Hospital Baltimore Baltimore 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 8. Date of Birth **Director** 212-54-1861 1 □ M 2**x** F 61 Oct. 19, 1950 Washington, DC Usual Residence of Deceder 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 E. Heather Road 21014 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the State of Maryland 12 Clerical traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P ည Richard Burton Ware Mary Susan Vetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Gintaras Sakalauskas / Husband 210 East Heather Rd., Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Svcs, LLC 2-25-2012 Bel Air, Maryland 21. Sirnalı 22. Name and Address of Facility McComas Funeral Home, P.A. of Funer I Sen 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ovarian cancer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of), cause. Enter Underlying Cause (Disease or injury and I-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No neral Director: A filled in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 ho To the Fune completely f Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ns Rajapathlu.D 50057465

DHMH 17 Rev 06-2011

State Registrar 3703

28355mish AV

Registrar's Signature

Baltimory MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, Mil)

31. Date filed (Month, Day, Year)

andali Paine v	vort	1- For State Registrar		Maryland	,	artment of rtificate of	Health and Death	d Mental F	, ,	Reg. No.		
Physici Medical Exam		Decedent's Name (First)			~				2. Date of De	ath Day	Year	3. Time of Death
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		Field behind 321	0 Aldino Road	d			Churchville			Harfo	rd	
Funeral Director		5. Social Security Number			Age (In yrs. la	•	If Under 1 Year Months Days			irth (MM/DD/Y	Forei	rthplace (State or gn
Director		215-54-4593 Usual Residence of Deced	1K M	2F	59 	Yrs			Nov.	6, 195	2 0	ountry) Maryland
*max		10a, State 10b, C			10c. City,	Town or Locati	on					10d. Inside City Limits
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with the Maryland ns 23a or 28a-f sho be notified at once.		217 Presco		Was Decede	ent Ever in II	S 13 Wa	21078 s Decedent of His		Specify Ves or N	USA		ican Indian, Black,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, N					<u> </u>	18.Mother's Nam				
2121 ald be f Mental marke	o Be	John Dalla 19a. Informant's Name/Rei			III	19b Mailing	Address (Stree		lizabetl Rural Route Nu			Zin Code) 0107
MD 3 d 2 shou lth and] u 27 is numatic	۲	Nancy Main			Wife		Prescott					21070
2 2 2 2		20a. Method of Disposition		amoval from S		Place of Disposi crematory or oth	tion (Name of cen	netery,	Date	20c. Location	on - City or	Town, State
Baltimore, permit. Pages 1 as Department of He important: If ite injury or other tr		4 Donation 5 Ot	her Specify:				n Cemete		28/2012			on, Maryland
Balt permit Depart Impor injury		Signature of Financia Si	ervice License	1	1		ame and Address					•
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/Medical ≞xaminer	i	failure. List only one Immediate Cause (Final di			wound	of hea	d					Between Onset and Death
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ox 6876 eath certificat eath certificat eath ding phy	sicia	past 12 months?	Unknown 4		at time of dea	🖃	er (Specify)					
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of Vital Records, g. Physician: The law require the this certificate has been si neral director, page 2 should t	Be	25. Was case referred to m examiner?	nedical Hospita					of Death (Check				
ing Physical dimeral di	٠ <u>۲</u>	1 ✓ Yes 2 No 27. Manner of Death	0	8a, Date of In	ijury	ER/Outpatient 28b. Time of In	3 - 3 - 3	y at Work?		Residence 6		: Scene
OD (tending sath.	tion	1 Natural 5 2 X Accident	Pending Investigation	(Month, Day,		fd 11:0	5 am 1 □ Y	es 2 X No	subject	shot	self	
VISION At after d Direct d in by	Certification	3 Suicide 6	Could not be	8e. Place of	Injury - At ho	me, farm, stree	, factory, office bu	uilding, etc.	28f. Location (or Town,	Street and Nur	nberorRu	ral Route Number, City ind 3210
Diving the complete or the com		4 Homicide 29a. Certifier		(Specify)	fie				Aldino	Rd. Ch	urchy	7ille,MD.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only	ing Physician: To ai Examiner:On the	ne basis of ex	amination an							
T _o vi	¥ ¥	29b. Signature and title of o		manner stated			29c. License	number		29d. Date si	gned (Mor	oth, Day, Year)
1		Pate	()~	- /8	all_	2	O.C.N	И.Е. 		February	23, 201	2
pered		30. Name and address of p Patricia Aronica-F				-	900 W. Baltim	ore Street. F	Baltimore. M	D 21223		
	ate	31. Date filed (Month, Day,	Year)		ar's Signatur					0		
Regist		FFR 9 8	2017	31	.67	But On Kal	•					

			For State of Maryland /	Department of Health and Mental Hygiene
_			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death Reg. No. 2012 05945
Phys M	sicia: edic	al	Clifton Williams	2. Date of Death Month Day Year Feb. 24, 2012 3. Time of Death 1051
Exa	ımine		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park 4c. County of Death Montgomery
Fune Direc	tor			Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nonths Days Hours Min. 9. Birthplace (State or Foreign Country) Wash. DC
Maryland 28a-f shov	numen at	Director	10a. State 10b. County 10c. City, Tow	n or Location Hyattsville 10d. Inside City Limits 1
with the	an Isa	Funeral Di	10e. Street and Number 6500 8th Ave.	10f. Zip Code 20783 10g. Citizen of What Country? USA
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 2715 marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event. the Medical Examinar must be notified at	al LAGIIIII et I		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Exam		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor 16b. Kind of Business/Industry Navy Yard
yland Ild be filed Mental Hy iarked oth		To Be	17. Father's Name (First, Middle, Last) Amos Williams Sr.	18. Mother's Name (First, Middle, Maiden Surname) Gladys Johnson
Mar and 2 shou lealth and im 27 is m				5. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 8th Ave. Hyattsville, MD 20783
timore t. Page 1 s trnent of I-			1√ Burial 2 ☐ Cremation 3 ☐ Removal from State MD N	of Disposition (Name of park) pate 20c. Location - City or Town, State park, crematory or other place) ational Cem. 3-2-2012 Laurel, MD
Bal permit Depar Impor	опсе		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695
Physicia Medio Examír	cal		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A CLUL O Due to (or as a consequence	reproviscular accident Interval Between Onset and Death
outed nd ransit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):
760 cate be executed physician and s the burial-transit	1	edical E	resulting in death) Last Due to (or as a consequence d.	οή:
Box 68 death certifi ne attending ed for use a		ξſ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year
Records, P.O. The law requires that the ate has been signed by the page 2 should be detach		3	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑Unknown
Reco		pajaidillos		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 Avo 1 Wes 2 Avo
Vital hysician: his certific al director,	i i		25. Was case referred to medical examiner? 1 Yes 2 Vo Hospital: 1 Inpatient 2 ER/Ou	26. Place of Death (Check only one) utpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
Division of Vital To the Hospital or Attending Physician: Whith 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		cel unicate.	1 Natural 5 Pending (Month, Day, Year) i	Time of njury 28c. Injury at work? M 1 □ Yes 2 □ No
DIVIS pital or Al purs after eral Direc filled in by			4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	City or Town, State)
o the Hos vithin 24 ho o the Fun ompletely		DO L	(Check 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, and due to the cause(s) and manner as stated. In investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Wedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
			Agene, MD	65780 2/27/12
- N	i de		30. Name and address of person who completed cause of death (Item 23a) (Jamus Human St. Date filed (Month, Day, Year) 32. Registrar's Signature	Dealth are Takoma perk MD
Regis	State strar		FEB 2 3 2012 Arms B.	barker

DHMH 17 Rev 06-2011

				e of Maryland	d / Depa	artment of H	lealth and	d Mental Hy	giene			
			State Registrar		Cer	tificate of D	eath		Reg. No. 2	12	0.51	946
	Physicia	an/	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of	Death
	Medi			oody				Februar		012	1:20	P ^M
	Examir	er	4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of De	ath	4c. County			
	Funeral		Gilchrist Center 5. Social Security Number 6. Sex	7. Age (In yrs. las	et hirthday)	Towso:	n If Under 24 H	rs. 8. Date of Birt		timor		
	Director		218-22-2283 1 □ M 2 🗵	₹ F	Yrs.	Months Days	Hours M	n. (Month, Da	y, Year)	Gouni	olace (State or try)	r Foreign
-	- Ma		Usual Residence of Decedent	84				March 5	, 1927	Mary	land	
	yland f sho ed at	혅	10a. State 10b. County	10c. City,	Town or Loc	ation				1	0d. Inside Cit	
	28a-	Director	Maryland Baltimore		Pho	enix					1 🗌 Yes	2 K No
	th the		10e, Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	14305 Phoenix Avenue V		40.14	21131			USA			
(0	or ite	by F	Arme	Decedent Ever in U.S. d Forces? Yes 2 X No	13. V	as Decedent of His Yes, specify Cubar	spanic Origin?	Specify Yes or No- erto Rican, etc.)		e - America k, White, e		
036	s afte ral", e Exan	g p	3 Widowed 4 17 Diversed If Yes	res 2 🕰 No i, Give or Dates.	1	☐ Yes 2 🏻 No	Specify:		Specify:	LTL	ite	
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7			09 n/	a	Sa1	es			Ret	ail_		
pu	e d al	To Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Surname)		
3	should be filk and Mental I is marked c raumatic eve	-	Robert Kinsey	Perry	,		Ev	a Ru	th	Rosi	er	
Ma	~ -1		19a. Informant's Name/Relationship (Type, Print)	- 11		- '		Rural Route Number		,		
رة ب	ge 1 and 2 should be it of Health and Mer if item 27 is marke or other traumatic		Linda Valentine/Sister 20a. Method of Disposition			Phoenix ition (Name of	Avenue	West, Ph			21131	
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once,		1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal	from State cer	metery, crem	atory or other place		Date	20c. Location -	,		
Ė	artme ortar injur		4 Donation 5 Other (Specify) 21 Signatured Funeral Service License	Atla		Crematory Name and Address		22/12	Glen Bu	ırnie	, Mary	land
ä	permi Depar Impo any ir		Dryanti Clary	Met	1	emmon Fur O_W. Pado	neral H Onia Ro	ome of Du ad, Timon	ium. MD	alley 2109	Inc.	
п			23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of	nat aus d the death. n ach li e.	Do not enter	the mode of dying	, such as cardi	ac or respiratory arre	est,		Approximate Interval Betw	
~	Physician/	61.3	Immediate Cau e (Final disease or con itio	coul	uonal:					104	Onset and D	eath
and a	Medical Examiner		resulting in dealing a. Due	e to (or as conseque	nce of):		V	20-0	\ 0.1.00.1.0			
		e	Sequentially list conditions, b.	to for as a consequen	063	wic ive	puli	mary c	risease		Jears	
	ed nsit	Examiner	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury	ार (जा वड व टजाडंटपूर्वज	nce on.							
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0	icate be executed physician and is the burial-transit	edical										
3760	ficate g phy as the		_ c									
Box 68	ss that the death certific igned by the attending is be detached for use as		Zob. was decedent pregnant	outcome of pregnanc Ive Birth 2 Fetal o		Estable breamana			23d. Date	e of delive	ry	
80 80	death	sicia	1 Yes 2 No 4 F	Pregnant at time of dea Unknown		Other (specify)			Mor	ith (Day Ye	ear
P.O.	t the	Phy	a - Olikilowii				-					
σ.	ss tha igned be de	ē	Part II. Other significant conditions contributing	to death but not result	ting in the un	derlying cause give	n in Part I.		bacco use contri		8.6	
<u>rds</u>	require been sign should	Completed						1 U Y	es 2 No	3 Proba	ably 4 U	nknown
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<u>ta</u>	ician Sertifi rector	m	25. Was case referred to medical examiner? Hospital:				ce of Death (Ch	eck only one)				
<u></u>	ding Physician: The la th. After this certificate ha funeral director, page '	<u>و</u>	1 res 2 Aino	Inpatient 2 EF	R/Outpatient 8b. Time of		4 ☐ Nursing	Home 5 Reside			hosp	Q
U O	ding th. After	cate	1 Natural 5 ☐ Pending (A	Month, Day, Year)	injury	28c. Injury a work? M 1 1 1 Ye	es 2 🗆 No	28d. Describe ho	w injury occurre	d		
Sign	Atter	Certificate:	3 Suicide 6 Could not be	ace of Injury - At home	e, farm, stree			28f. Location (St	reet and Number	r or Rural I	Soute Numbe	ur.
Division of Vital Records,	al or s afte l Dire		4 - Homicide determined bu	uilding, etc. (Specify)				City or Towr		Or Flurai I	loute rearribe.	',
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hoursal after death: within 24 hoursal Director. After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check Medical Examiner: On the	ne best of my knowled	lge, death oc	curred at the time,	date and place	, and due to the cau	use(s) and manne	er as stated	d.	nor state of
	the hin 24		only one) 3 L Certifying Nurse Practitio	ner: To the best of my	knowledge, c	leath occurred at the	time, date and	place, and due to th	d place, and due e cause(s) and ma	to the caus anner as st	.e(s) and mani ated.	ner stated.
	© 4 kit 9		29b. Signature and title of certifier			29c. License r	number		9d. Date signed			
			Marlins			1 772	2303		restow	my 2	0 20	12
	∞		30 Name and address of person who completed of	eause of death (Item 23	3a) (Type, Pri	harles Ci	Tom	DON MO				
	Stat				0.		, -	/				
	Registra	r	FEB 2 8 2012	Drews &	1. As	was						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 25, Physician/ February Shirley Anne Wier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center <u>Baltimore</u> Towson 6. Sex 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Davs Hours **Director** 212-28-4771 1 🗆 M 2 🗆 F Yrs. July 12, 1929 82 Usual Residence of Decede show 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f Timonium Maryland Baltimore ms 23a or must be r o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road, #AL313 21093 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. fant: If item 27 is marked other than 'any or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 02 Interior Designer Interior Design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johnson, Jr. Louise Bay1y Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendall W. Kroll/Daughter 6412 Murray Hill Road, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Signature of Funeral Service Liderische Bryan W. Clary 2/26/12 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart billure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Yneumon. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month 1 ☐ Yes 2 L 9 ☐ Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ PA Division of Vital Records,

e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifies ours after death.

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filled in by the fu

ted	Alrual filos	· Culion		1 ∐ Yes 2 L	No 3 □ Probably 4 □ onkn	iown		
Completed	Cougestine	Heart failure.		24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death? 1 Yes 2 No	able of		
بة ا	25. Was case referred to medical		26. Place of Death (Chec	k only one)	-			
To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other: 4 Nursing H	ome 5 Residence 6	Pother (Specify) HOSPIC	\in		
Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury	occurred			
al Certir	3 Suicide 6 Could not 4 Homicide determined		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medica	(Check 2 Medical Exar	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investiga irse Practitioner: To the best of my knowledge, de	tion, in my opinion, death occurred a	t the time, date and place,	and due to the cause(s) and manner	stated.		
-	29b. Signature and title of certifier		29c. License number	29d. Date	signed (Month, Day, Year)			
	1 Colonto	MD	D71040	ā	2 25 2012	-		
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	-				
	ARATHI KUMAG	2 6701 N CHARL	ES ST SUITE	4105 BF	LTIMORE MA			
ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature						
trar	FEB 2.8	2012 12 10	aled					
6-2011		Januar Joseph						

3. Time of Death

 A^M

7:00

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

White

Toomey

Interval Between Onset and Death

Year

Day

2012

Regis DHMH 17 Rev 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marion Havas Webster February 2012 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4515 Willard Avenue, #2303S Chevy Chase Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 011-28-2708 **Director** 1 □ M 2 🛣 F 81 September 17, 1930 Hungary Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location must be notified at Director Maryland Montgomery Chevy Chase 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 4515 Willard Avenue, #2303S 20815 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Budget Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bela Havas Vera Kollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra. Dr. Henry deF. Webster/Husband 4515 Willard Avenue, #2303S, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) February 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 26, 2012 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cortical Dementia Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Paraplegia Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 X No death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 뎯 2 🗆 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 🗆 Nursing Home 5 🔀 Residence 6 🗀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours to the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

Sharon Scanlon, M.D.

ranem MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D48043

5530 Wisconsin Avenue, Ste. 1445, Chevy Chase, MD 20815

29d. Date signed (Month, Day, Year)

February 24, 2012

			State of Maryland / Dep		Mental Hygi	ene			
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Re 2. Date of Death	g. No 2012			
	Physicia Medic		Arthur Wu		Month February	17, 2012	3. Time of Death 12:28 AM		
-	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c, County of Deat			
and the		м	Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Bethesda		Montgome			
	Funeral Director		5. Social Security Number 295-44-2343 Usual Residence of Decedent 6. Sex 1 K M 2 □ F 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Cou	thplace (State or Foreign untry) Van		
	rland f shov d at	후	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
	• Mary • 28a-i	Director		otomac			1 🗆 Yes 2 🔀 No		
	h with the ns 23a or nust be	Funeral [10e. Street and Number 10805 Willow Run Court	10f. Zip Code 20854		g. Citizen of What Co nited Stat	•		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces2 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Decedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, Mexican, Puerto Rican, etc.) 15. Race - A Black, Mexican, Puerto Rican, etc.)				
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "nati the Medica	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of work O NOT use retired) val Engineer	ing	6b. Kind of Business/I United Sta Government	ates		
yland	uld be filed I Mental Hyg narked othe	To Be	17. Father's Name (First, Middle, Last) unknown		e (First, Middle, Ma	iden Surname)			
, Mai	nd 2 sho ealth and m 27 is r		Susie Wu / wife 1080	ng Address (Street and Number or Rurs Willow Run Court			/		
timore	. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 Burial 2 Cormation 3 Removal from State 4 Donation 5 Other (Specify)	matory or other place) Marc	eh 8. I	oc. Location - City or Bethesda,			
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licensee MO1305 Regulation Annual MO1305	2, Name and Address of Facility Obert A. Pumphrey Fune 157 Wisconsin Avenue, I	cal Home/Be Bethesda, M	ethesda-Cheve aryland 2081	y Chase, Inc. 4-3501		
	Physician/		23a. Part 1. Inter the disease, or complications that caused the death. Do not ensource shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration	er the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death		
1	Medical Examiner	<u>.</u>	resulting in death) Due to (or as a consequence of): Chronic Concest	ive Heart Failure			1 Year		
_	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C	lmonary Fibrosis E	nd Stage		ll Years		
9	ite be executed hysician and he burial-transi	ical	resulting in death) Last Due to (or as a consequence of): d.						
Š R	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year		
s, P.O.	ires that t signed b Id be deta	ا ۾	Part II. Other significant conditions contributing to death but not resulting in the Atrial Fibrillation, Hypertension,			cco use contribute to	the cause of death?		
Vital Records,	e law requ thas beer ge 2 shou	Completed	Chronic Kidney Disease		24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of		
Ĭ	in: The		25. Was case referred to medical	OC Plans of Davids (Obs.)	performe	No 1 ☐ Yes	2 🗆 No		
Ž	ysicia is cer direc	To Be	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 X ER/Outpatien	26. Place of Death (Check		e 6 Other (Specif	5.4		
on or	ath. r: After th	Certificate:	27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time or injury	I.e. i.e.	28d. Describe how		<i>y</i>)		
DIVISION OF	tal or Atturs after de al Directo led in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,		
:	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death only one) 2 Medical Examiner: On the basis of examination and/or investigation on the basis of examination and/or investigation.	tigation, in my opinion, death occurred at	the time date and r	lace and due to the ca	guee(s) and manner stated		
	To t with To t		29b. Signature and title of certifier There's Charche.	29c. License number 0/3 3 3 9	29d	Date signed (Month,			
			30. Name and address of person who completed cause of death (Item 23a) (Type, F			laryland 20	0740		
ı	State Registra	•	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	ale					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS, G924, 2/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Doris Ann Willen 3. Time of Death Physician/ FEBRUARY 24 2012 04:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GOLDEN LIVING CENTER CARROLL WESTMINSTER If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F (Month, Day, Year) 06/29/1933 215-30-3890 Director 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 2006 SUFFOLK ROAD 21048 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give than "natural", Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH LEBEAU LILLIAN MILNER 1 and 2 should be fleath and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVIN WILLEN / HUSBAND 2006 SUFFOLK ROAD, FINKSBURG, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2012 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medica Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Due to (or as a consequence of) resulting in death) Last Physician/Medical phys the l as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 Yes 2 L 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed' certificate 2 P No 1 🗌 Yes Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🖳 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 \square Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Pwithin 24 29b. Signature and title of certifier Baun U39JU2 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Main St. Westminster MA Osal 447, h ed (Month, Day, Year State FEB 2 8 2012 Registra

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maurice Yancey 5:00A 24 February 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice e NW Hospital Randallstown Baltimore Social Security Number 6. Şex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 24 Hrs. Hours Min. **Director** 1 X M 2 □ F MD 12/26 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Randallstown MD 28a-f Battimore 1 Yes 2 No 2 should be filed within 72 ווכענט... Ith and Mental Hygiene. 727 is marked other than "natural", or items 23a or 28: מחלה event, the Medical Examiner must be not 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If fes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NQT use retired) during most of working Elementary/Secondary (Q-12) College (1-4 or 5+) Human Sorvices Accountan 12th grade 5+ years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clem Camper Jalley Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health an Important: If item 27 is: 1 ruesde/Niece Post Office Box 215 Kandallstown MD 21133 Jacqueline Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest DWIMAS MILLS, MD 02 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility aughn C. Greene Funeral Services Vaug 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End. Stage Dementia Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or de a consequênce of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and and burial-trar resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year detached 9 Unknown Unknown signed by t d be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Tother Specifier hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapalneM.D D0057465 2/24/12

Registrar

DHMH 17 Rev 06-2011

State

2835 Smith N

32. Registrar' Signature

5 203

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· S Rajapork & M.D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Joyce Flitcraft Zoellner Feb 26 2012 11:45 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sandy Spring Montgomery Friends House If Under 24 Hrs. 7. Age (In yrs. last birthday) If Unde Birthplace (State or Foreign Country) 8. Date of Birth Month: Min (Month, Day, Year) 340-22-9798
Usual Residence of Decedent 1 🗆 M 2 🗶 F 83 Nov. 17, 1928 Illinois 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Montgomery Sandy Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 17340 Quaker Lane Apt C-24 20860 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Flitcraft Alice Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6822 Jackson Ave. Falls Church, VA 22042 Gary Zoellner / son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/29/12 Woodbine, MD Signature Ineral Service Licensee elise Going Home Cremation Service, P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death VESHEOPET disease or condition resulting in death) Due to (or as a consequence of) TERINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 for use the signed by ģ Division of Vital Records, Completed peen To the Hospital or Attending Physician: The law After this certificate has Be ဂ္ Certificate: death. 24 hours after deat Funeral Director completely filled in by the Medical within 2 To the I

Physician/

Medical

Examiner

Funeral

Director

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"natural", or items 23a or dical Examiner must be

Page 1 and 2 should be filed within 72 hours after death

it of Health and Mental Hygiene.
If item 27 is marked other than "natu or other traumatic event, the Medical

Department of H Important: If ite any injury or ot

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Examine

Examiner

Baltimore, Maryland 21215-0036

at

notified 28a-f

Director

Funeral

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Completed

Be

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VEMUR

1 Natural

29a. Certifier

(Check

only one)

2 Accident
3 Suicide
4 Homicide

9501 GEORGE 32

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Year)

5 Pending

Investigation

determined

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>012</u> Year Louise Irene Zepp 3:57A Feb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 212-24-6950 Hours **Director** 84 1 🗆 M 2 🔀 2-18-1928 MD 28a-f show with the Maryland 10a. State be notified at 10c. City, Town or Location Director 10d. Inside City Limits Carroll MD Westminster 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 912 Old Westminster Pike 21157 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musone. USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XIo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William R. Stem Elmira Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Zepp Sr.-nephew 1201 W. Liberty Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pleasant Valley 2-29-12 Westminster, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home nones 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate nterval Between Immediate Cause (Final Onset and Death Ph sician/ respirator disease or condition nr Medical resulting in death) Due to (or as a consequence of Examiner Sep 513 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi tract intection urinam and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month signed by the at Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 autopsy performed?
Yes 2 No death? 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 💢 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00047575 02 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Westminster. Dr

State

Registrar

31. Date filed (Month

FEB 2

2012

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32. Registar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DKins Ebruary 7:25 PM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Halor Hospital N/A **Funeral** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 KY 8. Date of Birth 216-30-8892 **Director** 76 1 🗙 🗶 2 🗆 F 4/16/35 Usual Residence of Decede show 10a. State 10b. County must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD N/A 28a-f Baltimore XXYes 2 No 10e. Street and Number 10f. Zip Code Funeral I 10g. Citizen of What Country? 3804 Pennington Avenue items 23a 21226 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "Instural", or items Important: If item 27 is marked other than "instural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X X Yes 2 No
If Yes, Give by 1 Never Married 2 Married Army Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 53-56 Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Boilermaker Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Minzy Delong ည James Adkins 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City of Town, State, Zip Codel Pennington Avenue, Baltimore MD 21226 Loretta Jane Adkins/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State cemetery crematory or other 4 Donation 5 Other (Specify) Crownsville VA Cem 3/1/12 Crownsville MD Signature of Funeral Service Licensee Victor Doda Charles L. Stevens Funeral Home, Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Sersis-Probable Abdominal Source disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHF with Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Fraction 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I the Hospital or Attending Physician: 25. Was case referred to medical examiner 1 Yes 2 \(\square\$\text{No}\) Be 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide filled in by the Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laid,

31. Date filed (Month, Day, Year) FEB 2 9 2012 RES-001

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Registrar

SINDHUTA

1. Date filed (Month, Day, Year)

FEB 2 9 2012

MARUPUDI, 900

32. Registrar's Signature

CATON AVE, BALTIMORE, MD-21229.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 27, 2042 8:00 a M Augenia Alvey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Summit Park Health & Rehab Catonsville Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 K F Hours Maryland 6/26/1926 **Director** 216-20-8077 85 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified MD Baltimore Catonsville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code è 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 1502 Frederick Road 21228 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Il Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other th njury or other traumatic event, the Account Supervisor 12 Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Karolina Yurpolis John Drusutis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria A. Gillingham/Daug 18 Amberwood Way, Lewes, DE 19958 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 3/3/2012 Elkridge, Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cal shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mont Day Month Year Pregnant at time of death page 2 should be detached Unknown signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 2 No 1 🔲 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 -1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify To the magnitude within 24 hours after death.

To the Funeral Director: After this state of the funeral in by the funeral funeral 28c. Injury at 27. Manner of Feath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred atural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title o

and address

31. Date filed (Month, Day, Year)

9

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ORIGINAL

29d. Date sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ BIGGER STAFF 08:27 PM FEBRUARY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDSTAR HARBOR HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 007-18-2417 86 **Director** 1 M 2XXF 7/21/25 show 3a or 28a-f shov t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d, Inside City Limits Director MD Baltimore Lansdowne 1 Yes 2 XNo 10e. Street and Number 153 Clyde Avenue 10f. Zip Code 10g. Citizen of What Country? 21227 Funeral items 23a USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XXo Black, White, etc or by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXo Specify: Specify White Completed 3₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Computer Programmer Computer Be Nother's Name (First, Middle, Maiden Surname)
Ella Arel nd Mental F Adjutor LaFleur ပ other traumatic Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Der 153 Clyde Avenue, Lansdowne MD 21227 Ella C. Biggerstaff / Daughter Department of Healt Important: If item 2 any injury or other Baltimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ARdent Crematory 1 Burial 2 Xxremation 3 Removal from State 2/18/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph sician/ LACTIC ACIDOSIS Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Day Month Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\sime\) Yes 1 Natural injury 5 Pending Accident Investigation 24 hours after death e Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) RES-001

State Registrar

DHMH 17 Rev 06-2011

3001 S. HANOVER STREET, BALTIMORE, MD, 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		-	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2	5958
Phys	siciar edic		1. Decedent's Name (First, Middle, Last) Lela M. Baxter 2. Date of Death 3. T	ime of Death
	mine			Liny
Fune Direc	_		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	itate or Foreign
and show	ă	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ins	ide City Limits
e Maryl r 28a-f	nomine	Director	MD BATIMORE 100, Street and Number 100, Stree	¥Yes 2 □ No
with th	nst pe	Funeral	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1219 WALTERS AVENUE 21239 USA	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show for each the Macifold Exemination or items.	Xamilier III	ह	1 Never Married 2 Married 1 Yes 2 No	an,
5-00 hours natura	dical L	oletec	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business Industry	
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Maryla 2 should beth and Mer th and Mer 27 is mark	ranimar		19a. Informant's Name/Relationship (Type, Print)	
	ano		Theodore BAXTER (HVSBAND) 1219 WALTERS AVE · BAXTO, MD · 21239 20a. Method of Disposition 20b. Place of Disposition (Name of local 2) Date, 20c. Location - City or Town, St.	ate
and Page	igury or		1 Na Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State KING MEMORIAL TK 2/28/2012 BALTIMORE,	MD
Balt permit. Departr Imports	once	1	21. Signature of Funeral Service Licensee MIB36 22. Name and Address of Facility VAUGHN GREENE FUNERAL 4905 YORK ROAD. BATTIMORE, MD. 2.	1212
			23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, intervention of the cause of the	oximate al Between t and Death
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Ords, P.O. BOX 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.		Physician/Me	23b. Was decedent pregnant in the past 12 mgnths? 1	Year
DIVISION Of VITAI RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director, After this certificate has been signed by the atternormoleted filled in by the funeral director, page 2 should be detached for a		2	23e. Did topacco use contribute to the caus	
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On O onding l ath. rr: After		ertificate:	27. Manner of Death 1 X Natural 2	
LIVISION OT VITAI HECOTIS, tal or Attending Physician: The law requires re after death. al Director: After this certificate has been signed in your the funeral director, can est should by		ပ၂	Sity of Town, State)	Number,
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To th			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ar)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
)	01		Jettrey Hoseman 6609 Persone Braike Rd. Bostmare, on 212	-09
	State istra		31. Date filed (Month, Day, Year) FEB 2 9 2012 A Barket	

DHMH 17 Rev 7/2009

			For State Registrar	State of	Marylan		artment <i>tificate</i>			Mental Hy	20	12 05	959
	Physicia Medi		Decedent's Name (First, Middle Marian L. Bush	e, Last)						2. Date of De Month	Day	Year 3. Tim	ne of Death
	Examir		4a. Facility Name (If not institution Gilchrist Hospic 5. Social Security Number	e				Towson			4c. County o		30 р.
	Funeral Director		212–22–7207 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. la	ast birthday) Yrs.	If Under Months		If Under 24 H Hours M		ay, Year)	Birthplace (Sta Country)	te or Foreign
	e fled within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County	timore		y, Town or Lo	cation						e City Limits Yes 2 No
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36	fter death , or items aminer mu	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Deceder Armed Force 1 \(\sum \) Yes 2	s?	ŀ	f Yes, specif	ent of Hisp fy Cuban,	anic Origin? Mexican, Pu	Specify Yes or No- erto Rican, etc.)	14. Race	JSA - American Indian , White, etc.	
9	hours a natural' ical Exa	leted	3 X Widowed 4 □ Divorced	Year or Dates		16a. Deced	Yes 2				Specify:	African-A	American
21215-0036	led within 72 Hygiene. other than "r ent, the Med	Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4 c	or 5+)	(Give I life. D	kind of work O NOT use r	done dur etired)	ing most of wervisor	rorking	16b. Kind of Bus Baltimore	e City Sch	cols
Maryland	ould be filed within 7 d Mental Hygiene. marked other than matic event, the Mg	To Be	17. Father's Name (First, Middle, L Robert Lewis	_ast)				1		lame (First, Middle, Stewart	Maiden Surname)		
	sho han 7 is trau		19a. Informant's Name/Relations! Shontel Adams/ Gra							Rural Route Number Baltimore,	er, City or Town, Sta	ite, Zip Code)	
Baltimore,	T 75 E 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from Sta	ite C	lace of Dispo emetery, crem	sition (Name natory or oth	e of ner place)		Date	20c. Location - C	Dity or Town, State	,
Balti	permit. Page Department. Important: I any injury or		21. Signature of Funeral Service L		ALL		. Name and	Address	of Facility V	5–2012 Wlie Funer Mallstown.	Arbutus, al Home P.A	MD V. of Balto	o. Co.
	Physician/	V 1	234 Part 1. Enter the disease shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that causinly one cause on each I	sed the death ine.	n. Do not ente	r the mode	of dying,	such as cardi	ac or respiratory ar	rest,		mate Between nd Death
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birtl 4 Pregnant 9 Unknown	n 2 🗀 Fetal at time of de	death 3 🗌	Ectopic pre Other (spec				23d. Date Monti	,	Year
Division of Vital Records, P.O.	quires that en signed b		Part II. Other significant andition	ns contributing to death	but not resu	ulting in the ur	nderlying car	use given	in Part I.	23e. Did to	obacco use contribu	ute to the cause o	
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/ital	sician:		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Lou	of Death (Ch	eck only one)			2. 14
on of \	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of in (Month, D	jury 2	ER/Outpatient 28b. Time of injury		Injury at work?	4 □ Nursing	1	dence 6 Other own injury occurred	Specify) (**O \$	pice
Divisi	tal or Atte rs after de al Directo led in by th		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Place of Ir	njury - At hon tc. (Specify)	ne, farm, stre	et, factory, o	office		28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Nu	mber,
	he Hospi iin 24 hou he Funer ipletely fill	Medical	(Check 2 Wedical E:	Physician: To the best of kaminer: On the basis of Nurse Practitioner: To	examination	and/or investig	aation, in my	opinion, o	death occurred	at the time date a	nd place, and due to	has (s)osusond	manner stated.
	Noth Com		29b. Signature and title of certifier	\			29c. L	icense nu	mber		29d. Date signed (A	Month, Day, Year)	
		Ī	30. Name and address of person w	the completed cause of	death (Item 2	23a) (Type, Pr	8+.	× 41	05.	Balti	more,	MD 21:	104
	Stat Registra	е	31. Date filed (Month, Day, Year) FEB 2, 9 2(,52. Regisi	rar's Signatu	face	1		,				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician M 2012 /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baytimore
If Under 1 Year | If Under 24 Hrs.
Pays | Hours | Min. erlea Kena 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex. 1 M 2 □ F **Funeral** Months 243-40-4848 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine in unit by notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) mployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Branch ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MO 21213 Kos Daughter ayette 18a Hon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20/2012 Baltimore, MD. FIH-East 1101 E. North Ave. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21202 1. Enter the disease, or complications that could the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 2 □No 1 □ Yes Division of Vital Records, P.O. eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \square No 21N0 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 2 ☑ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes investigation 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 20b. Signature and title of certifier of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John F Beal1 Feb 22,2012 2355 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Md Hospital Clinton Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Month, Day, Year, Jan 29,1922 212-20-1401 **Director** 1 XM 2 □ F MdUsual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MdPrince George Uppermar1boro 1 Yes 2X No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 15408 Nottingham Rd 20772 Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specificaucasian Completed 3xxWidowed 4 □ Divorced Year or Dates. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical.
once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oden L Beall Mary E Bannin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis B Trexler(Daughter) 15300 Nottingham Rd Uppermar1boro Md 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Resurrection Cenetery Feb 28,2012 Clinton Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home f Funeral Service Licensee MO1391 6633 Old Alexandria Ferry Rd Clinton Md 20735 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Myocarchal Infarction Immediate Cause (Final Onset and Death Heute Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by febross Division of Vital Records, 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N**O Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending Natural 1 Yes 2 No 2 Accident filled in by the Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WA MD D0057800 57/1 Sawis owenus \$100 Riverdale, MD20737

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Multammab

ASHRAF, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 23a per dr., g924, 02/29/2012dhb Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10 20 6:30 Druary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat County of Death Examiner Tate Hospice House Linthicum Anne <u>Arundel</u> 8. Date of Birth (Month, Day, 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Months 1 😿 M 2 🗆 F 219-03-5234 921District of Columbia 91 Director Jan. Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2X No Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7400 Locust Drive 21076 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Dates: 1941–44 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 XDivorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Brick Mason Construction nt of Health and Mental Hyg If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William В. Brown, Sr. Esther ပ Benson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) August Cohen, daughter 9629 Heathermill Lane Raleigh, NC 27617 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/11/12 Baltimore, MD George MacNabb 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Cardiovas ular Disease** Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 \(\sumeq\) Yes 2 \(\sumeq\) No Hospital or Attending Ph. sician: The certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) completely within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 20/2 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD AG 4DD 2-106 Registrar's Signature Date filed (Month, Day, Year) State FEB 2 9 201 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BECKER 9:40 AM HOWARD FUBRUARY 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ESVILL TRANSITIONS CARE CARROLL HEALTH Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 XM 2 - F Months 3/194/1922 Marvland 214-18-3606 89 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examinar Terrains. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 1 Yes 2x No MD Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7220 John Pickett Rd. 21797 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3

Widowed 4 □ Divorced White Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Crown Cork & Seal Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adele Howard V. Becker Florence Co1e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7220 John Pickett Rd., Woodbine, MD. 21797 Sharron N. Jacobs (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Loudon Park Cemetery 2/27/12 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAL DISEASE END STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \square Yes Hospital 2 1 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner. On the basis of examination allow investigation, which is a stated and place, and due to the cause(s) and manner as stated 29b. Signature and tibe of certiful

State Registrar

Registrar FEB 2 9 2012

,DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

EUNAND RICHARDSON

32. Begistrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

057722

M.P. 1838 GREENE TREE ROAD #300 PILLEVILLE MO 21208

FEBRUARY 23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 24, **Physician** 2012 12:40 а м Bacanskas Jonas Vytautas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Manor Care 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min. Months Days 1 ☐ M 2 ☐ F 212-30-6972 1928 Lithuania 83 Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm "hedical Examiner must be notified all 1 □Yes 2 및 No Director Sykesville MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5586 Linton Rd. 21784 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ Xif Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. þ Specify: White 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Guard Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bucnys ပ Jouzas Bacanskas Rozaleia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar fitem 27 is or other tr 5586 Linton Rd., Sykesville, MD 21784 Melanie Biemiller (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place, Baltimore Crematory 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iten
any Injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2/29/12 Baltimore, Maryland Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aranam **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner las culan heral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-transit Hypertension Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of deatle? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≥</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t irector, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Many r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: 19 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCARA mo PAYAM 7505 05/08 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Barron 2012 7:30 PM Feb. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Co. Upper Chesapeake Medical Ctr. Bel Air . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 🙀 M 2 🗆 F Months Hours Maryland Director 216-20-7300 Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Dundalk Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 7806 Scholar Road 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1000 < |23| |3700| Baltimore, Maryland 21215-0036 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify. than "natural", Completed 3 XWidowed 4 ☐ Divorced Specify: WWII White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 10 Years Food Industry Salesman Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John McKee Barron Jenny Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Kevin J. Barron 2351 Searles Road Dundalk, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 2/29/2012 Towson, Maryland Hilltop Service Corp: ure of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Myocorchel Physician/ disease or condition resulting in death) an Medical a consequence of Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) detached for Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes Natural 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, year received at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0036487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Bel Ai Steen Bentman 32. Registre 's Signa ure 31. Date filed (Month, Day, Year) State 2012 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Dededent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year February 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ivy Hall Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** 1 □ M 2 🗓 F 215-22-3450 84 April 6, 1927 Maryland Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2X No MD Baltimore Essex ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21221 USA 941 Kinwat Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify "natural", 3 X Widowed 4 □ Divorced Specify Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the home nurse healthcare other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of မ permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Charles Thomas Beck Rose Mary Krall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T. Bressan - son 941 Kinwat Ave; Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature-RON 3 d S 21201 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or all consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed the burial-tran resulting in death) Last e to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 1110 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? After this certificate 1 🗌 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural hours after death. Ineral Director: A 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

FEB 29

			For State of M	aryland / Dep	artment of H	lealth and M	1ental Hyg	iene 2 n	12	059	67
			Registrar	Ce	rtificate of E	Death	R	eg. No.	1 1-		
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	T D	1		2. Date of Deat Month Februa		Year 2012	3. Time of I	
	Medic Examin		Ronald 4a. Facility Name (if not institution, give street and number)	J. Bu	eche	Location of Death	rebruai	4c. County		5:40	P ^M
) Examin		14015 Foxland Road		Phoe				timore	ē	
	Funeral			je (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla	ice (State or	Foreign
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	and show i at	o o	10a. State 10b. County	10c. City, Town or Lo	ocation			<u> </u>	100	d. Inside City	/ Limits
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	h the	a D	10e. Street and Number		10f. Zip Code		1	0g. Citizen of W			
	th wit ms 23 must	Funeral Director	14015 Foxland Road		211.		16.37		J.S.A.		
ဖွ	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 ☒ Married 12. Was Decedent Armed Forces? 1 ☒ Yes 2 □	No	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		e - Americar k, White, etc		
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		2. Name and Addres		ick Tows		ral Ho	ome, I	
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P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certificate: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a consequence of): a consequence of): of pregnancy 2 Fetal death 3 fat time of death 5 fout not resulting in the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of the pout not resulting in the series of th	Ectopic pregnance Other (specify) underlying cause giv 26. Pla 1 3 DOA Other 28c. Injury work M 1 reet, factory, office occurred at the time stigation, in my opinio	en in Part I. ace of Death (Checker: 4 \square Nursing Hore at 2 \square No a, date and place, ar n, death occurred at 1 \square number \square \square \square \square \square \square \square \square \square \square	1 ☐ Yes 24a. Was ar autops perform 1 ☐ Yes 2 only one) me 5 ★ Reside 28d. Describe how 28f. Location (Str. City or Town, and due to the cau the time, date and	More acco use contributes 2 No 24b. Who per section of the winjury occurred and Number State) se(s) and manner of place, and due to the country of the coun	e of delivery the Dute to the 3 Probal Probal Probal Property of the Property of the Property of the Property of the Cause of the Cause (Month, Da)	y Year)	eath 44/
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certificate: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a consequence of): a consequence of): of pregnancy 2 Fetal death 3 [at time of death 5 [but not resulting in the series of	26. Plant 3 DOA Other (specify) underlying cause giv 26. Plant 3 DOA Other f 28c. Injury work	en in Part I. ace of Death (Checker: 4 \square Nursing Hore at 2 \square No a, date and place, ar n, death occurred at 1 \square number \square \square \square \square \square \square \square \square \square \square	1 ☐ Yes 24a. Was ar autops perform 1 ☐ Yes 2 only one) me 5 ★ Reside 28d. Describe how 28f. Location (Str. City or Town, and due to the cau the time, date and	More acco use contributes 2 No 24b. Who per section of the winjury occurred and Number State) se(s) and manner of place, and due to the country of the coun	e of delivery the Dute to the 3 Probal Probal Probal Property of the Property of the Property of the Property of the Cause of the Cause (Month, Da)	y Year)	eath 44/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 28, 2012 Claire B. 3:30 A Barry Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Hours **Director** 1 🗆 M 2 💢 F 214-22-9214 84 2/2/1928 Maryland or 28a-f show notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore Timonium 1 🗌 Yes 2 🎗 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be I Funeral U.S.A. 620 Straffan Drive 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Narried 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur N. Bond Sarah Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 620 Straffan Drive # 301 Timonium, MD 21093 Robert T. Barry / Husband 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) 3/1/2012 Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): buria physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Month Day Year Pregnant at time of death 2 X No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The this certificate 2 🗌 No 1 🗌 Yes director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation the Funeral Director: upletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

CLAIRE BARRY

2012

FEBRUARY

DHMH 17 Rev 06-2011

Registrar

29b. Signature and

JACKIE JONES,

Day, Year) 2

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05969 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1925 Clyde Brathwaite 2013 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore City N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 580-09-9905 **Director** 1 🖳 M 2 🗆 F 12/02/1920 West Indies 91 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director N/A 1 ¥ Yes 2 ☐ No MD Baltimore 10e. Street and Number r items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 2804 Elsinore Ave. "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) self Employed of ith and Mental Hygien 27 is marked other the traumatic event, the 12th Grade Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Brathwaite Miriam unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Claudette Smith(Daughter) 6218 Golden Ring Rd., Baltimore, MD21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cem. 02/27/12 Baltimore, MD Signature of Funeral Service Licensee Jóseph Adesso Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, lams MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 3 days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sacral MUITING 2 month Sequentially list conditions, Examine if any leading to improceed cause. Enter Underlying Due to (or as a consequent...) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) been signed by the atte should be detached for in the past 12 months? Day Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Cere brovascular disease, Multiinfarct dementia, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Vascular Disease, Hypertension, Hyper-Were autopsy findings available prior to completion of cause of death? Peripheral 24a. Was an has page 2 autopsy Hyperlipi demico Director: After this certificate tensi on 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 - Natural 1 Yes 2 No filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) MI 22,2012 RES - DOU February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abraham Hospital More Hazel Baltimore 31. Date filed (Month, egistrar's Signatur State Registrar

DHMH 17 Rev 06-2011

Brathwaite

Sat ent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20/3° Physician/ Month 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death and so Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Country) **Director** 1 M 2 M 2 3-13-1940 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No indsor ō 10e. Street and Number 10g, Citizen of What Country? "natural", or items 23a Funeral 21244 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. p 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 nours after Specify: Black 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, Give kind of work done (ijfe._DO NOT use retired) during most of working and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Be 17: Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sulma ျှ permit. Page 1 and 2 should be Kobel 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Six Important: If item 27 any injury or other tra UShua Lole 4US bara 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State -2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License au 23a. Part 1. Enter the disease, or complice shock, or beart failure. List only one that caused the death. Do not enter the mode of dying, espiratory arrest on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine ue to (or as a Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregna 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 mont Month Day Year Pregnant at time of death page 2 should be detached signed by the 9 Unknown Part II. Other signifi conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) Manner Death Certificate: 28b Time of 28c. Injury at work? 1 🗌 Yes 28d. Describe how injury occurred To the Funeral Director: After 1 Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month CHRISTIAN Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner t. MORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 🗆 Months Days Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 No 1MM 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? 21203 Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle. 18. Mother's Name (First, Middle, Maiden Surname) ပ α 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Told Himal 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ☐ Burial 2 Termation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Ligensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician DEVECE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 🔼 № 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe this certificate 1 ☐ Yes 2 ☐ director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 200 Other: Certificate: To 1 🔲 Yes Tupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 5 29b. Signature a d title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 27 Olga Zawadsky Carr 20°1′2 12:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Timonium Social Security Number 8. Date of Birth (Month, Day, Year) March 9, 1920 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 220-09-6846 **Director** 1 □ M 2 **X**F Maryland 91 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other tranmatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 🏋 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 United States 409 Virginia Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) medical secretary 2012 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Zawadsky Natalya Dementyuk 27, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cockeysville, MD Robert F. Carr Sr./son 12 Ivy Hill Ct. FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery Mar. 3,2012 Elkridge, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. <u>Baltimore</u>, MD 21212 Ole O. Mitchell 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami death certificate be executed use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day been signed by the s should be detached 9 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 🗌 No Yes 2 X No 1 🗌 Yes eral Director: After this certificatilled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗶 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No injury X Natural 5 Pending Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

04

Registrar

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

MORGAN,

TRACIE L.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1435 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Hospital Annapolis Anne Arundel 5. Social Security Number If Under 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 215-20-8945 **Director** 1 □ M 2 🗓 F 88 10-28-1923 North Carolina Usual Residence of Deced 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Annapolis Anne Arundel 1 🗌 Yes 2 🄀 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2723 Cabernet Lane 21401 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 han "natural", c If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify 3 Nidowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the and Mental Hygier is marked other t Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental I.
Important: If item 27 is marked any injury or attended. 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Moore Ruby Constance Riner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Loetz - daughter 2723 Cabernet Lane, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 $oxed{oxed{A}}$ Burial 2 $oxed{oxed}$ Cremation 3 $oxed{oxed}$ Removal from State Meadowridge Mem. Park 02-28-2012 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signet f Funeral Service Licensee 7250 Wash. Blvd., Elkridge, MD 21075 Inc, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset and Death DIRATION Physician/ disease or condition resulting in death) Medical Due to (or as a conviguence of) Examiner civintietly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medica 28. Place of Death (Check only one) Other: 2 1 No 1 Yes မ Tinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) en Chai Lebruary

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who

Day, Year)

31. Date filed (Month,

DEFENSE HIGHWAY

completed citize of death (Item 23a) (Type, Print)

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	Funeral Director		216-28-4585	ex 7. Ag	e (In yrs. la: 81	st birthda Yrs	Months Davs	If Unde Hours	Min. (/	Pate of Birth Month, Day, Venber	Year) C	rthplace (State or Foreign Country) ryland	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or	Location				-	10d. Inside City Limits	
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:	should be filed within 72 hours after death with the Maryland not Mental Hygiene. Ind Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 3001 Scotch Court			10f. Zip Code 21009					10g. Citizen of What Country? USA		
	items items ner mi	inne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		. 1	 Was Decedent of H If Yes, specify Cub 	lispanic C an, Mexic	Origin? (Specify ' an, Puerto Ricar	Yes or No- n, etc.)	14. Race - Am Black, Wh		
030	urs aft af", or Exami	þ	3 Maried 2 Invaried 3 Maried	1 ☐ Yes 2 【文】 If Yes, Give Year or Dates:	10		1 ☐ Yes 2 🛣 No	Specif	fy:		Specify: W	hite	
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2 0	Hygid Other ent, th	Be Co	12 years 17. Father's Name (First, Middle, Last,)				18. Mot	ther's Name (Firs	st, Middle, M	Maiden Surname)		
/land	Menta Menta Irked	To B	Salvatore P. Bises	si				Sop	hie C. 1	Bisesi	L		
Mar	alth and 2		19a. Informant's Name/Relationship (Mark Camponeschi	Type. Print)			ailing Address <i>(Street</i> 1 Scoth Co					Zip Code) 11009	
baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Pla Cea	ce of Di metery, o Law	sposition (Name of crematory or other pla n Cemetery	ce) 7	March ^{te} 2012		20c. Location - City o Dundalk, Ma		
Dall	permit. Departr Importa any inju		21. Signature of Funeral Service Licer	(gnu	elly	-	22. Name and Addre Connelly 7110 Soll	ss of Fac Fune ers	ral Home Point Re	e Of I	oundalk,P. Oundalk,MC	A. 21222	
- 10,	Y.		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused one cause on each li	the death	Do not	enter the mode of dyi	ng, such a	as cardiac or res	spiratory arre	est,	Approximate Interval Between Onset and Death	
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ם ס	Phys	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ry	R/Outpa 28b. Tim	e of 28c. Inju	4			ence 6 Other (Sp ow injury occurred	pecify)	
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	To t To t	Σ	29b. Signature and title of certifier	Attend	Lina		29c. Licens		er 3 ろ	-	9d. Date signed (Mo	nth, Day, Year)	
٠,١	./		30. Name and address of person who	completed cause of d	leath (Item	23a) (Ty		1			way	MN 2D	
	\ V Sta	te	31. Date filed (Month, Day, Year)	32. Posistr	ar's Signati	ire		Lev	ne#	410	IONZUI	1000	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 0357 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Himore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 177-34-9519 Director 67 1 🗆 M 2 🔀 F 8/4/44 PA show 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA West Chester Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1670 Fox Crossing 19380 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary Banking Be 17. Father's Name (First, Middle, Last)

James M. Greer 18. Mother's Name (First, Middle, Maiden Surname, Marcella Dyzenkows) ဂ္ဂ Dyzenkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1670 Fox Crossing West Chester PA 19380 Edward H. Davis, Jr. /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place)

Birmingham–Lafayette

2/18/2012

Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 XXemoval from State 4 Donation 5 Other (Specify) West Chester, Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Panurahns Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No the Hospital or Attending Physician: The 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 **\ti**/No ဂ္ ☐ ER/Outpatient 3 ☐ DOA Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury Mammer of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accius. Suicide Investigation Accident To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of q RES-DOD address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfest Baltimore MD 21287 mno State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01/27/2012 Gean De'Arlingtone III 3:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death 3800 W. Belvedere Ave #301 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Months Days Hours 218-22-9836 85 12/18/1926 X M 2 D F Director CA Usual Residence of Decedent 28a-f show ms 23a or 28a-f shomust be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 3800 W. Belvedere Ave #301 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. altimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Trucking 12 Truck Driver event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gean De'Arlingtone II Marquriette Antiono permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is market any injury or other traumatic eonee. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1445 Bosworth Rd Kinston NC 28504 Cynthia Harris Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2/22/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv e of Futteral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a c Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) law requires that the death certificate be executed ause (Disease of Injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Į in the past 12 months? Month Day Year Pregnant at time of death the a detached 9 Unknown a Unknown signed by till de be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an after death.

Director: After this certificate has autopsy performed? Yes__2UNC Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 200 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1/2 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Rashida February 28, Darashaw Daruwalla 2012 5:30 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Gaithersburg Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 213-29-6298 **Director** 1 🗆 M 2 🛣 F ebruary 14,19<u>1</u>7 95 India Usual Residence of Decedent 28a-f shov 10a, State the Maryland 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director MD Montgomery Rockville 1X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Jersey Lane 20850 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Asian If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) 12College (1-4 or 5+) Homemaker of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cawas Masalawalla Jeroo Masalawalla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Hoshang Darashaw Daruwalla/Son 107 Jersey Lane Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 3/1/2012 Glen Burnie, MD Signature Funeral Service I 22. Name and Address of Facility Fleck Funeral Home NI 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving shock, or heart failure. List only one cause on each ine Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year the i 1 Yes 2 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available page 2 s autopsy performed? Yes 2 N prior to completion of cause of death? 1 T Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ieral Director: Ai filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurs ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 00062435

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year,

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BEATRICE Month 02 13 DYSON 20^{Year}_{12} 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RINCE GEORGES HYATTSVILLE SACRED HEART HOME 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Months Days Hours Min 94 0172671918 577-26-0176 Director Washington, DC Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince Georges 1 X Yes 2 ☐ No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Queens Chapel Road U.S.A. 20782 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 Yes, Give 1 ☐ Yes 2X No Specify. 3 🗆 Widowed 4 🗆 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) 12yrs. $\overset{\text{College (1-4 or 5+)}}{1 \text{yr}}$ U.S. Postal Service Supervisor in postal srvc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mr. Lewis Hawkins Mamie Davige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Brooks / adopted son 9505 Caltar Lane, Ft. Washington, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Date Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Signal use of Funeral S rvice Licensee Romald S Wave 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC ARREST disease or cond 5mths. Medical resulting in death) Due to (or as a consequence of) Examiner MYOCARDIOPATHY sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events years Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit HYPERTENSION years Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death N/AMonth Day Year Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBRALVASCULAR ACCIDENT 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen FAILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed?

1 Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ျ 1 🗌 Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 \square Pending e Hospica. In 24 hours after death. he Funeral Director; Aft 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse) Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 10810 Darnestown Road, #202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Raman Tuli

FEB 2

31. Date filed (Month, Day,

D19609

02/14/2012

20878

Gaithersburg, MD

12-01228 Yvonne Dietrich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 05979

		1- For State Registrar		Ce	rtificate o	f Death					Reg. No.				
Physicia		Decedent's Name (First, Midd	le,Last)						2.	Date of De	ath		. 1	3. Time of Death	
edical Exami	ner	Yvonne Dieti	rich							February	Day 10, 2	012 Year		1510 hrs	
		4a. Facility Name (if not institution		umber)		4b. City, Tow	n, or Lo	ocation of	Death		40	c. County o	f Death		
		1050 E. 33rd Street A	pt. 308			Baltimo	re								
Funeral		5. Social Security Number uni	_6. Sex	7. Age (In yrs.	last birthday)	If Under 1	\rightarrow	If Under	_					hplace (State or	unk
Director		213-52-8282	1 M 2 X F	66	Yrs	Months .	Days	Hours	Min.	July	24,	1945	Foreigi Cou	intry)	
		Usual Residence of Decedent													
any		10a. State 10b. County		10c. City	, Town or Local	ion								10d. Inside City L	imits
	_	MD		l E	Baltimon	e								1 X Yes 2	No
Maryland 28a-f show d at once.	용	10e. Street end Number				10f. Zip Co	de			1	10g. Cit	izen of Wh	at Coun	try?	
th the Maryland 23a or 28a-f sho notified at once.	Director	1050 E. 33rd	d St: Apt	308		212	218				-	ISA			
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ath w	Funeral	11, Wanta Otatas		orces?		is Decedent of es, specify C					10-	White		an Indian, Black,	
er dez	교		1 Yes	2 X No	4	Yes 2X	No.					Specify:	whi	te	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Š	3 Widowed 4 Div	or Dates:		16a, Deceder				nd of wor	k dono III	H 16h				
hour fuatu Exar	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		ost of working					10D.	KING OF BUS	siriess/ii	idustry CIIIC	
36 thin 72 than '	Ple	unk	٠,	nk											
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	o Be	John Dietrich 19a. Informant's Name/Relations			10h Mailin	Addross /	K	<u>Kathr</u>	yn S	henk	umbas C	it. of Tour	Ctoto	Zin Codo)	
shoul and N	۲	Deacon Joseph	h Krysiak	Clergy	7 34	Address (4 Frai	kTo	ord A	ve.	Balt	imor	e MD	212	063	
≥ Pd da		20a. Method of Disposition			Place of Dispos					Date				Town, State	
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Pag Pag ment		4 Donation 5 X Other Sp		te Mo	st Holy	Redee	mer		3/8/2	2012	Ва	ltimo	re,	MDON	
Baltimore, permit. Pages I as Department of He Important: If ite		21. Signature of Funeral Service	Wade.	Directo	22. Mi	lame and Add	ress of	f Facility	Stat	4 Ana	tomy	Boar	45	BelAir R	₹đ.
E E G & C		/X1111/1/	we		-6	DO W.	Dal.	CIMO	IE D	c, Da	LLTI	ያልቸች የ _መ	io:	11.7120)6
Physician		23a. Part I. Enter the diséase, or failure. List only one cause		caused the death	. Do not enter t	he mode of d	ying, su	ich as car	rdiac or re	espiratory a	rrest, she	ock, or hea	rt	Approximate Int Between Onset	
/Medical Examiner		Immediate Cause (Final disease	a. Congestive	e Heart Failu	re									Death	
Zammer		or condition resulting in death)	Due to (or as	a consequence o	of):										
		Sequentially list conditions,	b										_		
	<u>.</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence o	of):										
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):										
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760, cate be executed physician and he burial - transit	/Medical	UNPENDED	AMENDED												
, P.O. Box 68760, res that the death certificate be signed by the attending physici be detached for use as the buri	ŝ	IF FEMALE:	23c. If yes,	outcome of preg	nancy						23	d. Date of o	delivery		100
587 rrtific ling p		23b. Was decedent pregnant in the past 12 months?	I TIVE			tal death	3	Ectopic p	oregnancy	У	1	Month	D	ay Year	1
Box 687 death certifine attending by for use as t	Si			nant at time of de	eath 5 Dt	her (Specify)									
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Vital ysician:	B B	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Ott	her ₄	Nursing H	lome 5	Reside	ence 6 🗸	Other:	Scene	
I Of ing Ph	P.	27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time of I	njury 28c.	Injury a	at Work?	28	d. Describe	how inju	ury occurre	d		\neg
ion of tending Ph eath. tor: After t	희	1 Natural 5 Pend	ding	ii, Day, real)	 	1	Yes	s 2 🗌 N	No						
Division tal or Attendi rs after death.	2		stigation 28e. Plac	ce of Injury - At h	ome, farm, stree	et, factory, off	ice build	ding, etc.	28	f. Location	(Street a	and Number	r or Run	al Route Number,	City
Division To the Hospital or Attendit within 24 hours after death. To the Funcral Director: /	Certification:		d not be (Specify))						or Town,	State)				
Hospi 4 hou fune ely fil		20a Cortifies	hysiciam: To the be	st of my knowled	ge, death occur	red at the tim	e. date	and place	e, and du	e to the cau	use(s) an	nd manner a	as state		$\neg \neg$
the 1	Medical	(Onton only	miner:Dn the basis	of examination a	-										
F Wind	Se l	29b. Signature and title of certifie	and manners	stated.		29c. Li	cense n	number			29d.	Date signe	d (Mon	th, Day, Year)	
		///	/			0	.С.М.	E.			Feb	ruary 11	, 2012	2	
OCME		30. Name and address of person	win constituted cou	se of death (Itom	123a)						Ь.,				
		Mary G. Rjople MD.	Deputy Chief		,	W. Baltim	ore S	Street. E	Baltimo	re, MD 2	1223				
91	ate	V		egistrar's Signa											
Regist	rar	31. Date filed (Month, Day, Year), FEB 2 9	2012 /	was A	gack										
DHMH 17 Rev 1/2	001				ORIGINA										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G925 3/02/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bertha Antoinette Driscoll 1358 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist <u>Takoma Park</u> Montgomery If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year 1925 02/24/2012 Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 4F Months Hours Country) **Director** 419-32-0657 VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 68 Sheridan ST NE 20011 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: Completed Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Dietetic Assistant NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ၉ is marked permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Fred Scott Sadie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 68 Sheridan ST NE Washington, DC 20011 Jimmie Lee Driscoll/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔣 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) <u>:03/07/2012 | Arlington, VA</u> rlington Cem. 21. Sign tu e of Fyneral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 9th ST NW Washington, DC 20011 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Houte Cerebrovascular Medical resulting in death) Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Sta Mal physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? To the Funeral Director; After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Day Month Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy performed? prior to completion of cause of death? this certificate 2 No Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 100 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. al Director: After th 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMINA Universely East IVM SPM

31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

amend 19a-b, 20b, per fh, g926 4-17-12 sm
Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend 1tem 19a per fh g924 2-29-12 vt
State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	Cei	rtificate of D		, ,	ene 9. No. 2 ()	2 05981		
Physic		1. Decedent's Name (First, Middle, Last)	Thurston Ray	Everly		2. Date of Death Month 2/8/	/2012 Yes	3. Time of Death 5:00am M		
Med Exam		4a. Facility Name (if not institution, give stree Somerford Place	,	4b. City, Town, or L	ocation of Death	2,0,	4c. County of D			
Funera Directo		5. Social Security Number 6. Sex 405–22–3279	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yo	ear)	Birthplace (State or Foreign Country)		
		Usual Residence of Decedent 10a. State 10b. County	Yrs.	cation		6/18/24	1	KY		
Marylan 28a-fsb otified	Director	MD Howa		Columbia	ι			10d. Inside City Limits 1 Yes 2 □ No		
with the s 23a or ust be n	Funeral D	10e. Street and Number 8220 Snowden Rive	er Parkway	10f. Zip Code	21045	10	g. Citizen of What	Country? USA		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumattic event, the Medical Examiner must be notified at more.	۾	11. Marital Status 12 1 Never Married 2 Married 2 Nidowed 4 Divorced	Armed Forces? WWII	Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2 XXII	, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White		
21215-0036 within 72 hours after giene. ier than "natural", o.; the Medical Exam	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) (Give	dent's Usual Occupat kind of work done du O NOT use retired) Personne	tion tring most of working L Manager	g	Sb. Kind of Busine Bell So	·		
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Box 68' death certificate attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
ords, P.O. Bc requires that the dea been signed by the a should be detached f	ρ	Part II. Other significant conditions contri	outing to death but not resulting in the u	inderlying cause giver	n in Part I.			to the cause of death?		
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by that filled in by the funeral director, page 2 should be detach	Completed					24a. Was an autopsy performe	prior 1	autopsy findings available to completion of cause of ? Yes XX No		
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Division tal or Attenc rs after deatt al Director, led in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28	3f. Location (Stree City or Town, S		Rural Route Number,		
To the Hospital within 24 hours: To the Funeral I completely filled	Medical	(Check 2 \(\sum \) Medical Examiner:	n: To the best of my knowledge, death of On the basis of examination and/or invest actitioner: To the best of my knowledge,	tigation, in my opinion,	, death occurred at th	ne time, date and p	place, and due to th	ne cause(s) and manner stated.		
29b. Signature and title of certifier 29c. License number D56531 29d. Date gigned (Month) 27872012							Day, Year)			
		30. Name and address of person who comp Harry Li MD, 8600	leted cause of death (Item 23a) (Type, P Snowden River Park	rint) cway # 301	, Columbi	a MD 210	045			
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 9 201	32. Rigistrar's Signature	have						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 05982 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LIAM 1335 PM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-18-0486 **Director** 1**X** M 2 □ F 87 April 1, 1924 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford Street Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral 21154 3310 Forge Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. White 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Civil Service 12 Ordnance Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William S. Ellers, Sr. Floye Loftin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 Forge Hill Rd, Street, MD 21154 Beuna Ellers - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harford Memorial Gdns. 2/28/2012 Aberdeen, MD 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory urest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown been signed by t should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 N/n 1 Yes ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ke Dr. Bel Air State Registrar

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Michael Victor Edelstein	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	2	0090
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		Registrar		•	Certifica	ate of	Death			F	Reg. No.			
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		St. Joseph's Hospita		uniber)				Location of	Death					
		St. Joseph's Hospita					Towson				l B	aitimore	e County	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under 1 Yea		24Hrs.	8. Date of B	rth(MM/	DD/YYYY)	9. Birthplace	(State or
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State of Maryland / Department of Health and Mental Hygiene									05001
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	Funeral Director		5. Social Security Number 320-36-2116 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 10/26/42	9. Birth Cour 2 II	
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	!		30. Name and address of person who complet	ted cause of death (Item 23		387	Balhia	4/16/1	7,221
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			TED E O EVIL	MANAGE P.					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23, 20/2 **Physician** 10:55 AM Fe bruary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 60 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-8-192 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 10 M 2 F Hours Min. 82 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code with 54 items 23a 2120 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò Specify: Blac 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 'nstural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 321 Limore MD 21207 Dil 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages to Department of Himportant: If ite any injury or ot once. cemetery, crematory or other place 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State -1-2012 * 4 ☐ Donation 5 ☐ Other (Specify) Limore 22. Name and Address of Facility (a U) 21. Signature of Funeral Service Licensee Gircege Funeral Services he Riad /Kanda/15 town 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed fran and burial-f Due to (or as a consequent Box 68760. physician Completed by Physiclan/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the th 9 Unknown 9 Unknown by signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours aft To the Funerel Di comptetely filled in To the Hospitel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

OURS HOSPITAL, 2000 W. Ba

29c. License number

L0060225

29d. Date signed (Month, Dey, Year)

1timore Street, Baltimore, MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#8perFH, G927,5/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 05986 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard Fuhrman Physician/ 0/21/19/20/12 8:15 a_M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 555 W. Towsontown Blvd Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1934 9. Birthplace (State or Foreign Country) **Funeral** 479-36-1795 Days Hours Min. 0471577935 Director 1**X** M 2 □ F 77 IA Yrs. 10a. State Ħ 10c. City. Town or Location Director 10d. Inside City Limits notified 28a-f MD 1 X Yes 2 No Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral 1929 East Pratt Street 21231 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc.
White þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. 4 yrs (1-4 or 5+) Elementary/Secondary (0-12) Salesman Sales Be of Health and Mental H f item 27 is marked ot r other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Fuhrman Dorothy 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Reagan Wife it of Health a 1929 East Pratt Street Baltimore MD 21231 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Command 3 Removal from State Department or Important: If any injury or once. ō Atlantic Crem 02/22/12 Glen Burnie MD 4 Donation 5 Other (Specify) permit. Fureral Service License 22.Name and Address of Facility Simplicity Crem & Fun Sery ThomasAllen PA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) roles rousseulor accident M Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical death certificate be Box 68760 as the attending IF FEMALE: nse s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for Day Pregnant at time of death Month Year signed by the a 9 Unknown g 🗌 Unknown P.O. or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO Hospital 1 Tes Other: မှု 1 Inpatient 2 I ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined hours after Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 9 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State

Registrar

9

12-01614 Stervin Ferguson	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	
	1- For State Registrar Certificate of Death Reg. No. 2 1 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.	0598
Physician/ Medical Examiner	Stervin K. Ferguson Month Day Year February 24, 2012	Time of Death 2242 hrs
<i>y</i>	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center 4b. City, Town, or Location of Death Bel Air 4c. County of Death Harford	
Funeral Director	5. Social Security Number 217-82-2318 6. Sex 1/2 M 2 F 48 Yrs. 1 Months Days Hours Min. Aug 23, 1963	
the Maryland is or 28s-f show any difficed at once. Director	10a. State 10b. County 10c. City, Town or Location 10c	d. Inside City Limits Yes 2 No
s after death with ral", or items 23 iner must be no by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 No Specify: Blac.	k
5-0036 ed within 72 hour 1/1/1/2 hour 1/1/2 ene. other than "natu the Medical Exan Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemical Engineer Bitumar USA	,
215-0 be filed v ntal Hygi rked oth ent, the I	Earl Taft Margaret Beverly	
MD 21 d 2 should tht and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Ethel L. Ferguson (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1708 Harbinger Trail Edgewood, Md. 2	21040
imore, Pages I ann ment of Heal tant: If iten or other tra	201. Metriod of Disposition 1	n, State
. (21. Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21	1213
Physician /Medical 	23a. Fait it. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. At	pproximate Interval etween Onset and Death
9	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
at Xaminer	Co. Due to (or as a consequence of):	
760, itate be executed physician and the burial - transi	d. UNPENDED AMENDED	
ox 68 attending or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
P.O. Be es that the de igned by the be detached if by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the c	
Division of Vital Records, P.C. tal or Attending Physician: The law requires that is after death. Al Director: After this certificate has been signed led in by the funeral director, page 2 should be determined in the funeral director.	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	y findings available letion of cause of 2 No
irector	25. Was case referred to medical examiner? 1 Ves 2 No Other: 1 No Inpatient 2 Residence 6 Other: 1 No Other: 1 No Norsing Home 5 Residence 6 Other: 1 No Other: 1 Norsing Home 5 Residence 6 Other: 1 Norsing Hom	
on of V anding Phys ath. r: After this he funeral di	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Roor Town, State)	oute Number, City
To the Hos within 24 ho To the Fun completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number	

ut ii. Other significant conditions	contributing to death bi	ut not resulting in the u	nderlying cause	given in Part I.	1 Yes 2	e contribute to the
					24a. Was an autopsy performed?	24b. Were auto prior to co death? 1 Yes
. Was case referred to medical			26.Place	e of Death (Check only	one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 FR/Outpatient	3 DOA	Other Nursing Ho	ome 5 Residenc	e 6 Other:

25. Was case referred to medical	26.Place of Death (Check only one)							
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	4 Nursir	ng Home 5 Residence 6 Other:			
27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at V	Vork?	28d. Describe how injury occurred			
1 Natural 5 Pending	(Month, Day, Year)		1 Yes 2	2 No				
2 Accident Investigatio								
3 Suicide 6 Could not b		ome, farm, street, factor	y, office buildin	g, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
4 Homicide determined	(Specify)				or rown, state)			

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
anesz	O.C.M.E.	February 25, 2012

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.	Assistant Medical Examiner	900 W. Baltimore Street.	Baltimore, MD 21223
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31. Date filed (Month, Day 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

OŘIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 23.43 marles (Sibson 02 ୍ଷ 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6/9/51 9. Birthplace (State or Foreign **Funeral** Year) Country) 60 Months Days Hours Min Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State ms 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits MD N/A Baltimore Director 1 XX es 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5411 Water Avenue 21214 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Air ONE of the control of the contro traumatic event, the Wedical Everniner 1 Never Married 2 ☐ Married 1 ☐Yes → Specify: \$ Specify: African American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mail Processor US Postal Service 17. Father's Name (First, Middle, Last) Johnny Gibson, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Lee Woodham ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 s tment of Health ar tant: If item 27 is i jury or other trau Penelope Samuel /Niece 232 Promise Lane, Hartsville SC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Calvary Baptist Church Cemetery 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hartsville, 4 Donation 5 Dother (Specify) 21. So return of Powers Victor P. Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final hysician disease or condition resulting in death) DEPSIS 2 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cuscas or n jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and ise as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò prior renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 peripheral autopsy performed 1 □ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 1 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001

24 hours a within 24 hou To the Fune completely file

Medical

29a. Certifier

(Check only one)

David

29b. Signature and title of certifier

Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

127

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1669764692

Baltimore MD

29d. Date signed (Month, Day, Year)

2/9/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 24a,25 per me,g924,02/29/2012dhb
Req. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 13 Physician /Medical Janice Grant February 2012 14:17 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 01-14-1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**F 217-56-8598 60 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director MD Yes 2 No "natural", or items 23a or 28a-f s dical Examiner must be notified BALTIMORE 10e. Street and Number 10g. Citizen of What Country? CEDONIA AVE - APT 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 KNo Specify <u>À</u> Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) WAZMART ALES CLERK Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental MYDA HEPBURA GREGORY, SR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Department of Health a Important; if item 27 is any injury or other tra once. GRANT SPOUSE NATHANIEL AVE APTE · BACTIMOYE, MD 21206

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDONIA Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/12 BALTIMOVE, MD PARK Wood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of acility VAUGHN GREENE FUNERAL SUS 4905 YORK RUAD BATIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebellar Hemorrhage **Physician** disease or condition resulting in death) day //Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1. ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 X Yes 2 ☐ No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 5 \square Residence မ 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 February 13, 2012 MD, PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

park

4940 Eastern Avenue, Baltimore, MD, 21224

MDIPHD

enun

32 Registrar's Signature

David P. Benavides

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 05991

		1- For State Registrar		Ce	ertificate o	f Death			Reg.	No.		
Physicia Vedical Examir	n/ ier	1. Decedent's Name (First, Middl Mark Go	rdon					Fe	ate of Death Ionth Debruary 25	Day Yea 5, 2012	r	3. Time of Death 1523 hrs
		4a. Facility Name (if not institution Northwest Hospital Ce	_	umber)		4b. City, Town, o Randallsto		f Death		4c. County of Baltimore		nty
Funeral Director		5. Social Security Number 218-76-5202	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da		Min	Date of Birth	мм/DD/YYYY 1957	Foreign	
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. County Ray	Limore	2	y, Town or Locat	ion // // 10f. Zip Code	15					10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Funeral Director	10e. Street and Number 210 Mid F	ines C	ourt x	10+.3C	10f. Zip Code	1117		10g	. Citizen of Wh	at Count	ry?
r death	by Funera	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divi		2 No	lf Y	as Decedent of H 'es, specify Cuba Yes 2 N	an, Mexican, I			14. Race White Specify:		an Indian, Black,
ਲ ∄ ॢ ∄ ặl	Completed t	15. Decedent's Education (Spec Elementary/Secondary (0-12)		de completed) 1-4 or 5+)		nt's Usual Occupa lost of working lif			done 1	6b. Kind of Bus	iness/in	dustry L Ban K
21215-0036 ould be filed within 7 imarked other than in marked other than ic event, the Medical	8	17. Father's Name (First, Middle,	Gordon	1, Sr.	Lion Mailia	Address	Hat	Hie.	L. (hrist	/	, Sur. (
MD 2 and 2 shou salth and N em 27 is n	_	Macilyn Gol 20a. Method of Disposition	don/W		2101	mid P	inesc	Dat	Ad. 3	C, City or Town C, Dwi. 20c. Location -	195	Zip Code) 3///7 Mills MD own, State
Baltimore permit. Pages 1 a Department of He Important: If its		1 Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:	rom State	, /	1 1	ss of Facility	3-3-0	2012 0 ireen	Balt Te Fuge	imo ral:	re, MD 3 rvices
Physician	+	23a. Part I. Enter the disease, or failure List only one cause	complications that o	aused the death	87	28 Lib	ofty.	ROP R	anda	1/5×000	1, 1	Approximate Interval Between Onset and
}/Medical ,£xaminer		Immediate Cause (Final disease or condition resulting in death)	a.Hyperte	ensive (scular	Diseas	e			-	Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	a consequence	of):							
cuted ind transit	Exa	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence								
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lox 68 eath certifi e attending for use as t	cian	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?) 1 Yes 2 No 9 Unk	e 1 Live b	nant at time of d	2 Fe	tal death 3 her (Specify)	Ectopic p	pregnancy		23d. Date of o	delivery Da	y Year
s, P.O. E nires that the d is signed by the	á	Part II. Other significant conditi Chronic Alcoh					given in Part	i I. 2			_	e cause of death?
Records, The law requir Tote has been s	Completed							— _{]1}	24a Was an autopsy performe Yes 2	pr ed? de		psy findings available mpletion of cause of 2 No
Vital Recysiciae: The Institute this certificate by director, page	8 3	25. Was case referred to medical examiner?	Hospital:	Innationt 2 a	ER/Outpatient		e of Death (C				1	
Division of Vital Records, P.O. cal or Attending Physiciae. The law requires that the ra after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	ation: To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pend 2 Accident Inves	28a. Date (Month		28b. Time of li	njury 28c. Inju	ury at Work?	28d.		sidence 6 vinjury occurre		
Divis pital or A purs after or cral Direc	린		not be mined (Specify)	e of Injury - At h	nome, farm, stree	et, factory, office	building, etc.		ocation (Street Town, State		or Rura	I Route Number, City
Division To the Hospital or Atteotwithin 24 hours after death To the Fuoeral Director: Completely filled in by the		one) 2 Medicai Exam	ysician: To the bes niner:On the basis and manner s	of examination a		ion, in my opinio	n, death occu					
		29b. Signature and title of certifier Theodox W	4 King	TRUE		29c. Licen	£1	CME		9d. Date signer ebruary 26		
		30. Name and address of person Theodore M. King, Jr.,	MD. Assista	ent Medical I	Examiner !	900 W. Baltir	more Stree	et, Baltim	ore, MD 2	1223		
Sta Registr	_	31. Date filed (Month, Day, Year) FFR 2 9 20		egistrar's Signat	ure							
DHMH 17 Rev 1/200)1		130.00	1	ORIGINAL	L						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THEOLOGRE FEMAUARY LOYL Medical 4c. County of Peath 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, HEALTH EARE SYSTEM PERRY POIN 7 7. Age (In yrs. last birthday)
Yrs. If Under Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Director arylend 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ✓ Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Method of Disposition 20c. Location - City or Town, State Date ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 9 funeral Horne, P. A. North 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate HEPATOCELLULAR Immediate Cause (Final UN KNOON •^Dhysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Discrept at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month ate has been signed by the a page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 N death? 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) 2 V No Other: 1 Yes 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending after death. Director: Aft Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital or within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WORKTHWO 31. Date filed (Month, Day, Year) 32. Registrar's State 2 9 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Emil Gutenplan 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HICOH HOWAVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Da 1 🕅 M 2 🗆 F Hours Austria Director 205-24-9437 97 Dec Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4730 Atrium Court #648 21117 ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black. White, etc. 1 Never Married 2 Married Completed by Yes filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give "natural", 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 aluminum company foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fanni Gutenplan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11050 Doxberry Cir; Woodstock, MD 21163 Judith Blanco - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Signature Funeral Service Licen 22. Name and Address of Facility State Anatomy Board my 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Athoroscieron Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) signed by the attending physician and de detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) HSS, Fled L Nin မြ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident work 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 3 Sulcide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

3. Time of Death

7 45 AM

1 Yes 2 No

Interval Between

nset and Death

Year

02 - 20-2012

Registrar DHMH 17 Rev 7/2009

State

edar Lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh g924 2-29-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar 5994 Certificate of Death Reg. No.1 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Betty Hildreth B. 5:10 AM 02-05 9017 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicamico Coastal Hospica at the Lake Salis bary 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month. Day, Year) 373-16-7562 Months Days Hours Min. 94 **Director** 1 ☐ M 2**XX**F Yrs. 2/1/18 MI Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MA Winchendon Worcester - Winchedon 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 517 Central Street 01475 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? WWII Black, White, etc. þ 1 Never Married 2 Married timore, Maryland 21215-0036 1 Yes 2 XXO Specify: White If Yes, Give 43 - 45Hildreth Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or မ William Amber Meech J. Rodgers other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traum once. Michael Hildreth / Son 29600 Mitchell Road. OPP. 36467 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 XXemoval from State 2/10/12 Winchendon, Riverside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda ²² Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 MC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hen **Physician** -owhere CVA disease or condition Medical resulting in death) Due to (or as a consequen **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buris Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 24 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 2 No 1 Yes A No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 60 642 Certificate: 27. Manner of Death 28b. Time of ac s after death. 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier D 63199. 2/5/12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YOGESH VOHRA 910 EASTERN SHOKE DR SALISBULY, MD, 21804, 31. Date filed (Month, Day, Year) State FEB 2 9 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eth er Physician/ 24, a012 H:11 1:30PM ebruary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2418 Annor Baltimore Court . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year If Under 24 Hrs 9. Birthplace (State or Foreign Months **Director** 1 M 2 □ F 28a-f show 10a. State **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits notified Baltimore MD 1 Yes 2 No 10e. Street and Num ò 10g. Citizen of What Country? 21230 TMOOR 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian ed other than "natural", or ite event, the Medical Examiner med Forces?
Yes 2 \(\square\$ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than aboves Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ E.leanor Route Number, City or Town, State, Zip Code)
Windsor Mill, MD 21244 Health attem 27 i 2 Shadwell Department of Health Important: If item 27 any injury or other tr of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State Dwings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) -2012 21. Sis nature of Fune a Service License Servi Immediate Cause (Final Physician/ inset and Death Dehydration disease or condition month Medical resulting in death) Examiner 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (of as a someguenes of burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should Ormary Tract Infection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate Yes 2 No 2X No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this vithin 24 hours after ueau..

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 005569 February 28th, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. Jan MD Greene Street 2120 Norch State Registrar

DM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Ernest Halstead State of Maryland / Department of Health and Mental Hygiene 2012 05996 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death William Ernest Halstead Month Day February 10, 2012 Medical Examiner 2045 hrs 4a. Fecility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1820 Spence Street, Apt. 313 **Baltimore** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Dete of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director 214-56-7447 60 03/27/1951 Country) MD 1 M 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10e State 10b. County 10d. Inside City Limits Dundalk show MD Baltimore 1 Yes 2 No items 23a or 28a-f shoust be notified at once. with the Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 2109 Dundalk Ave 21222 USA Ճ Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: ≧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h tent of Health and Mental Hygiene.

int: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Driver Auto Parts 2yrs 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Marian White B 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Dundalk Ave Dundalk MD 21222 19a. Informant's Name/Relationship (Type, Print) Melissa Halstead wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 2/25/12 Glen Burnie MD Department 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitySimplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and /Medical Death Methadone Intoxication and Ethanol Use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, Pt.II, 27, 28a-f, per me, g925 3-7-12 **X** UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcoholism with Cirrhosis Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has performed? death? certificate l' ector, page ✔ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital 8 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗹 Other: Scene this 2 1 🗸 Yes 2 No After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: within 24 hours after death.

To the Fuoeral Director: A completely filled in by the fur ___ Natural 5 Pending 1 Yes 2 X No unknown fd 2-10-12 | fd 8:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1820 Spence St. Apt 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) Found at Residence Homicide Baltimore, MD 29a. Certifier Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E February 11, 2012 2 of pers ress of person who completed cause of death (Item 23a) OGNIE Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registra DHMH 17 Rev 1/2001 OCME 2006

State

ature

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Humphrey Day Jeffrey Year Month Physician/ W 12:451 M February 16 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 1 🛛 M 2 🗆 F 51 10/15/1960 MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f st notified MD Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r by Funeral 33 Beaver Oak Court 21236 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Black, White, etc 1 Never Married 2 Married 1 Yes Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 8yrs Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Betty Jean Perkins John Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Beaver Oak Court Nottingham MD 21236 Jaime Robinson Daughter Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 XCremation 3 Removal from State 02/16/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser of Buneral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Phylician End-Stage Liver disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on The law requires that the death certificate be executed g physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page perform 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 4 - Nursing Home 5 - Residence 6 Other (Specify) Hospital 2 No Other: 1 Tes ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No М 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ms Rajapathe M.D 000 57 465 2/16/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. 5 Rajapakk 200 283.5 Smiln /N 5 763 Baltmore MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink./Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. Or 4:00 PM 2012 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne nove If Unde Year) 1927 Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date or Bird. (Month, Day, Y Country) MD 1 🗆 M 2 🗓 Months Hours Min 85 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No tanover 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21076 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 146 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 ₩idowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumests. Elementary/Seconday (0-12) College (1-4 or 5+) cation Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden 2 19b. Mailing Address (Street and Number 1egrass 302 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, tanover 4 Donation 5 Other (Specify) House 21. Si MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause and line. Approximate Interval Between Immediate Cause (Final Onset and Death rea disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin and tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🗷 ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) Natural 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending Accident 2 🗌 No 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number D 641 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 HOSPITAL DR. GLEN BURNIE, M_D Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 25 17:22 PM Physician Teb 2012 Mal /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Secours If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Year 1 M 2□ F 50-22-7309 South Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f ehow edical Exampler must be notified at 1 Yes 2 No Director ti MORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ¥ith roca d Dorne Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race 11. Marital Status 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 17 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. important: If Item 27 is marked other than "I any injury or other traumatic event, the Mes. 9068. Elementary/Secondary (0-12) College (1-4or 5+) 0 arr - Lowery laintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 10 2 nn 19a. Informant's Name/Relationship (Type, Print) [Str.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12 +14 Windsor 0 Hal Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Jown, State 20a. Method of Disposition ☑Burial 2 ☐ Cremation 3 ☐ Removal from State orraine Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faoring 21. Signatural f Funeral Service License reralltons, P.A. 221W. 21216 North 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Eist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) : li cosis **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 9 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 21 No certificate 2 No 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 X Inpatient Other: 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funerel Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide pellil 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 6626 Harne and address of person who completed cause of death (Item 23a) (Type, Print) abataba Date filed (Month, Day, Year) State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of M State Amend Items 3,23a per	aryland / Dep fh/dr., g9	partment of h 2/102/29/ artificate of L	Health and Me 2012dhb Seath	ental Hygiei Reg.	ne No. 2017	0 00000	
	Physicia						2. Date of Death Month	Day 9 Year	3. Time of Death 2 4:45p M	
	Medie Examir		4a. Facility Name (if not institution, give street and number) Manor Care Roland	4b. City, Town, or Location of Death			4c. County of Death			
	Funeral Director			ge (In yrs. last birthday) 98 Yrs.	- 1	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Bird 913 Ma	thplace (State or Foreign untry) arvland	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits	
21215-0036			MD	Balti	more				1 √ Yes 2 □ No	
			10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?	
			1100 Bolton St; Apt 501 11. Marital Status 12. Was Decedent	Ever in LLS 13	Was Decedent of H	ispanic Origin? (Speci	fy Vee or No.	USA	deserted in	
			11. Mantal Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 Will If Yes, Give Year or Dates.	No	If Yes, specify Cuba	an, Mexican, Puerto Ri	can, etc.)	14. Race - Ame Black, White Specify: b1 a	e, etc.	
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bo			17. Father's Name (First, Middle, Last)	wa	TCTCSS/ Sa	18. Mother's Name (First, Middle, Maid		idsery	
ylar			Howard L. Johns			Carrie	E. Bower	S		
Maryland			19a. Informant's Name/Relationship (Type, Print)		9b. Mailing Address (Street and Number or Rural Route Numb					
			Romona Johnson – granddaug			e Ct; Plan			~ 0	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🗓 Donation 5 ☐ Other (Specify)	' ·	ematory`or other plac			. Location - City or	Iown, State	
Ba	Depar Impor any irr		21. Sign tup of Funeral Service Licenses Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201							
	Physician). Medical	Completed by Physicia	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):							
100	I or Attending Physician; The law requires tha after death. Director: After this certificate has been signed in by the funeral director, page 2 should be de		Sequentially list conditions, b.							
90			if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	nce of):					
			resulting in death) Last Due to (or as a consequence) d.		ence of):					
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. Box 68760			in the past 12 more hs?	Ins? 1 Live Birth 2 Fetal death 3				23d. Date of delivery Month Day Year		
ds, P.O.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown			
Recor							24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of	
Division of Vital Records,		To Be	25. Was case referred to medical examiner? 1							
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			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)				f. Location (Street City or Town, Sta	on (Street and Number or Rural Route Number, Town, State)		
_			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
			29b. Signature and title of certifier	mo		0069314		Date signed (Month	1012	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M: Hal (raj grad 8813 Waltham Woods Rd Partille MD 2234)							
	Stat Registra		In Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 9 2012 A Sauce							